Municipal Health Benefit Fund

Effective December 1, 1981 (As Amended January 1, 2013)

The Municipal Health Benefit Fund is not insurance, and the Fund is not under the Rules and Regulations of the Insurance Department of the State of Arkansas.

Mandatory Administrative Appeals Procedure

As a condition precedent to all the benefits, terms and conditions of this contract, an employer member and all its covered members must agree to exhaust all their administrative remedies including, but not limited to, the claims denial procedure before the Board of Trustees before any legal actions are brought in any court.

Fund Administrative Office
P.O. BOX 188, North Little Rock, AR 72115
501-978-6137

American Fidelity Assurance Company

American Fidelity and the Arkansas Municipal League

American Fidelity Assurance Company is a select partner of the Arkansas Municipal (AML), and is dedicated to providing its members with quality employee benefit solutions and beneficial employer services.

AML has chosen American Fidelity as its partner because of our commitment to the municipal market. We serve more than 15,000 public sector employers nationwide. Our experience in this market allows us to design benefit plans that fit your specific needs, and our salaried, career Account Managers are available year-round to deliver the level of personal service you deserve.

Endorsed Voluntary Benefits

- Disability Income Insurance
- Life Insurance
- Cancer Insurance
- Accident Only Insurance
- Hospital Indemnity Insurance
- Critical Illness Insurance

Section 125 Administrative Services*

With more than 25 years of experience providing Section 125 Administrative Services, American Fidelity is an industry leader that currently services more than 8,000 Section 125 Plans nationwide. Our staff will help you establish your plan and help keep you up to date with the latest regulatory changes and other relevant information.

American Fidelity can help maximize your Section 125 Plan by adding Flexible Spending Accounts (FSA) to your plan. We offer FSA recordkeeping services, Health FSA Debit Cards, and a uniform risk coverage policy for Health FSAs.

A Trusted Partner

Founded on the principles of fairness and financial security, American Fidelity continues to achieve success as one of the nation's largest family-owned life and health insurance company.

- Rated "A+" (Superior) by A.M. Best Company since 1982, one of the nation's leading insurance company rating services.[1]

To learn more about partnering with American Fidelity, contact Bubba Spragins at 800-450-3506, ext. 3043, or email bubba.spragins@af-group.com and/or Charles Angel at 800-450-3506, ext.3132, or email charles.angel@af-group.com.

* American Fidelity is a Section 125 Plan service provider, but not the Section 125 Plan Administrator.

[1] www.ambest.com/consumers, June 21, 2011 (A+ is the 2nd highest rating out of 16 possible ratings with one being the highest.)

MUNICIPAL HEALTH BENEFIT FUND (Health Fund No. 1)

Effective December 1, 1981 (As Amended January 1, 2013)

DECLARATION OF TRUST

The provisions of this Municipal Health Benefit Fund Booklet are subject to the terms and conditions of the Declaration of Trust as amended.

This booklet describes benefits available to you under the Municipal Health Benefit Fund. Consult your Employer to determine the amount of your Life Benefits and to determine if your group has Disability Income Benefits. The self-funded Municipal Health Benefit Fund may be amended or discontinued by giving sixty (60) days' notice by regular mail to member cities and other public entities at their regular business addresses. It is the responsibility of the Participating Employer to notify its employees of any amendments or changes of the Municipal Health Benefit Fund.

Federal law no longer allows a self-funded, non-federal, governmental plan such as the Municipal Health Benefit Fund to exempt its plan from the requirements listed below;

(1) Limitations on preexisting condition exclusion periods;

(2) Special enrollment periods for individuals (and dependents) losing other coverage;

(3) Prohibitions against discriminating against individual members and beneficiaries based on health status;

However, Federal law allows a self-funded, non-federal, governmental plan such as the Municipal Health Benefit Fund to exempt its plan in whole or in part from the requirements listed below and the Municipal Health Benefit Fund has elected to do so.

(4) Standards relating to the Mental Health Parity and Addiction Equity Act;

(5) Standards relating to the Women's Health and Cancer Rights Act;

(6) Standards relating to benefits for mothers and newborns;

What this means to you:

- Employees and Dependents nineteen (19) years of age or older may be subject to benefit limits unless they had 12 months of continuous coverage under another plan within 63 days prior to enrollment in this Plan.
- Employees and Dependents will be able to enroll if they have a qualifying event during the plan year as outlined in this booklet.
- No individual will be declined coverage, charged a higher rate or receive lesser benefits based on a medical condition. Effective dates of coverage under this Plan are set out in this booklet.
- Mental Health Benefits are not part of the Major Medical Benefits under the Plan; therefore certain limitations and/or exclusions relating to Mental Health and Addiction benefits may apply as outlined in this booklet
- Following a covered mastectomy, the Plan will pay for treatment of both the affected breast and the unaffected breast to restore symmetry.
- The duration of a hospital confinement for a mother and newborn following the birth of a child will be determined based on eligibility. See "Maternity and Newborn Child Care on page 14 for more information.

The Plan cannot exempt itself from the requirement to furnish certificates of creditable coverage. Employees and Dependents will be provided with a written certificate of creditable coverage at the time their coverage ends. The certificate will show how long the Employee or Dependent was covered under the Plan and date the Employee's or Dependent's coverage under the Plan ended. Employees and Dependents may request a certificate of creditable coverage at any time.

PATIENT PRIVACY

The Plan does not sell, market or otherwise distribute your medical and personal health care information. However, the Plan may release medical information to persons who are engaged in the determination of claim eligibility and for the processing or appeal of a claim.

The specifics of coverages provided by the Plan are contained on the following pages.

Plan Administrator

Table of Contents

Section 1, Summary of Benefits and Coverage

This is only a summary. The complete terms of your coverage are outlined starting in Section 2, Benefits, of this Fund Booklet. They are also available at www.arml.org or by calling (501)978-6137.

Important Questions	Answers	Why this Matters:
What is the overall deductible? (Check with your Employer)	$500, $1,200 or $2,000 Covered Member / $6,000 Family (Does not apply to Preventive Care)	You must pay all costs up to the deductible amount before MHBF begins to pay for covered services you use. The deductible starts over each January 1st. The chart on the next page is an example of how much you must pay after you meet the annual deductible.
Are there other deductibles for specific services?	Yes, $50 for Routine Dental and $50 for Routine Vision per Person	You must pay all costs up to the deductible amount before MHBF begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, for In-State, In-Network Providers it is $4,000 per Covered Member, $8,000 per Family	The out of pocket limit, or stop loss, is the most you would pay during an annual coverage period for Covered Services. This limit helps you plan for health care expenses. (Does not apply to Out-of-State PPO Providers nor any Non-PPO Providers.)
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance billed charges and services MHBF does not cover	Even though you may pay these expenses, they will not count toward the out-of-pocket (Stop Loss) limit.
Is there an overall annual limit on what the plan pays?	No	The chart on the next page describes any limits on what MHBF will pay for specific covered services, such as an office visit.
Does this plan use a network of providers?	Yes – See www.arml.org or call MHBF for a list of participating Providers	After the calendar year deductible, MHBF will pay the following percentages: 80% PPO (In-State) Providers 80% PPO (Out-of-State) Providers 50% Non-PPO In-State or Out-of-State Providers Be aware: Your PPO Provider may use a Non-PPO Provider for some services.
Do I need a referral to see a specialist?	No	You may see the Specialist you choose without permission from MHBF.
Are there services this plan doesn't cover?	Yes	Some of the services MHBF does not cover are listed in this document. See Health Care Exclusions for additional information about other excluded services.

- Copayments are fixed dollar amounts (for example, $20) you pay for a basic office visit, usually when you receive the service.
- Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example in Section 2, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If a Non-PPO provider charges more than the allowed amount, you may have to pay the difference. For example, if a Non-PPO hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- MHBF encourages you to use MHBF PPO Preferred Providers to help lower deductibles, copayments and coinsurance amounts.
- Precertification is required for many covered benefits. Please call (888)295-3591 for Precertification questions. (Failure to precertify will result in a $1,500 penalty deductible.)

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/20% coinsurance	$20 copay/50% coinsurance	None
	Specialist visit	$20 copay/20% coinsurance	$20 copay/50% coinsurance	None
	Other practitioner office visit	$20 copay/20% coinsurance	$20 copay/50% coinsurance	Chiropractors, Dental & Eye Care Providers do not require the $20 copay.
	Preventive care/screening/immunization	$0	$0	Non-PPO Providers can balance bill any costs above the usual and customary amounts paid by MHBF.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (PET Scans, MRIs)	20% coinsurance	50% coinsurance	Limit of 2 PET scans per year

Questions: Call **501-978-6137** or visit us at www.arml.org. If you aren't clear about any of the terms used in this form, the Glossary can be viewed at www.arml.org or you may call the number above to request a copy.

Municipal Health Benefit Fund (MHBF)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: January 1, 2013 to December 31, 2013

Coverage for : Employees & Families | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	$10 copay	N/A	Align Pharmacy copay is $4
	Preferred brand drugs	$30	N/A	See Prescription Drug Coverage
	Non-preferred brand drugs	$50	N/A	See Prescription Drug Coverage
More information about prescription drug coverage is available at www.arml.org.	Specialty drugs up to $1000 Specialty drugs from $1000.01 or higher	$50 copay $100 copay	N/A	See Prescription Drug Coverage
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Non-PPO Providers can balance bill any costs above the usual and customary amounts paid by MHBF.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Non-PPO Providers can balance bill any costs above the usual and customary amounts paid by MHBF. Limit of 2 Elective Surgeries per year.
If you need immediate medical attention	Emergency room services	$250 copay 20% coinsurance	$250 copay 20% coinsurance	Non-PPO Providers can balance bill any costs above the usual and customary amounts paid by MHBF.
	Urgent Care	20% coinsurance	50% coinsurance	Non-PPO Providers can balance bill any costs above the usual and customary amounts paid by MHBF.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	30 days annually
	Physician/surgeon fee	20% coinsurance	50% coinsurance	Non-PPO balance billing applies
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	24 visits annually
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	10 days annually
	Chemical Dependency	20% coinsurance	Not Covered	Must use MHBF CDT Provider(s) 1 lifetime Treatment Plan
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	Non-PPO balance billing applies
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Non-PPO balance billing applies
If you need help recovering or have other special health needs	Home health care/Skilled nursing care	20% coinsurance	50% coinsurance	20 visits annually
	Rehabilitation services acute (inpatient)	20% coinsurance	50% coinsurance	30 days annually
	Rehabilitation services sub-acute (inpatient)	20% coinsurance	50% coinsurance	15 days annually
	Durable medical equipment	20% coinsurance	50% coinsurance	
	Transplant benefits	20% coinsurance	50% coinsurance	1 per lifetime
	Hospice service	20% coinsurance	50% coinsurance	90 days lifetime
Or if you need	Bariatric Weight Loss Surgery	20% coinsurance	Not Covered	Must use MHBF MBS-AQIP Center(s)
If your child needs dental or eye care	Eye exam/Glasses	20% coinsurance	50% coinsurance	Up to $150 annually
	Routine dental care	20% coinsurance	50% coinsurance	Up to $1,200 annually Excluded Services & Other Covered Services:

PLEASE NOTE: Out-of-Network Providers can balance bill any costs above the usual and customary amounts paid by MHBF

QUESTIONS: Call **501-978-6137** or visit us at www.arml.org. If you aren't clear about any of the terms used in this form, the Glossary can be viewed at www.arml.org or you may call the number above to request a copy.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (These are just a few samples. See Health Care Exclusions for other excluded services.)

- Acupuncture
- Cosmetic Procedures
- Work Related Injuries
- Infertility Treatment
- Private Duty Nursing
- Long Term Care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium which may be significantly higher than the premium you pay under MHBF. Other limitations on your rights to continue coverage may also apply.

For more information contact MHBF at 501-978-6137, or you may contact the Arkansas Insurance Dept., the U.S. Dept. of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa or the U.S. Dept. of Health & Human Services at 877-267-2323, ext. 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. Please see the instructions below or call us at 501-978-6137.

A denial of a claim for benefits will be explained in writing. The explanation will include the specific reason for the denial. The explanation may also provide a description of additional information you might be required to provide for reconsideration of your claim and an explanation of why it is needed. If you have a question about your claim payment or how the Plan works, we urge you to call and visit with a MHBF Customer Service Representative. If a claims question cannot be resolved through Customer Service, the following claims appeal procedure will be followed.

First Written Appeal—to request a written appeal, address a letter to the attention of the Claims Supervisor, at Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115. The request must be submitted within 60 days of your receipt of the claim denial notice. In your request for review and appeal specifically state why you believe the denial was incorrect.

Board of Trustees Appeal—if the decision rendered by the Claims Supervisor is not satisfactory, you or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a review to the Plan Administrator and the Municipal Health Benefit Fund Board of Trustees. The request should be directed to the Plan Administrator at P.O. Box 188, North Little Rock, AR 72115. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

For more information, please see Mandatory Administrative Appeals Procedure in the MHBF Fund Booklet.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Coverage Examples

Municipal Health Benefit Fund (MHBF)

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,550
- **Patient pays** $1,990

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500, $1200, or $2000
Co-pays	$10 (Prescription)
Coinsurance	$1,490
Limits or exclusions	None
Total	**$1,990 (if $500 Deductible)**

Managing type 2 diabetes
(maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $2,780
- **Patient pays** $1,320

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$500, 1200, or 2000
Co-pays	$20
Coinsurance	$820
Limits or exclusions	None
Total	**$1,320 (if $500 Deductible)**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

×**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

×**No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓**Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses

Section 2, Benefits

Benefits

Major Medical Schedule of Benefits

Individual Medical Coverage	Lifetime	No Maximum Dollar Limit
Acute Inpatient Rehabilitation	Annual	30 Days
Sub-Acute Inpatient Rehabilitation		15 Days
Bariatric Weight Loss Program*		
Chemical Dependency Treatment	Lifetime	1 Treatment Plan **
Chiropractic Services	Annual	12 Visits
Diabetic Training	Annual	1 Day Session
Elective Surgical Procedures (Hospital or Ambulatory Surgery Center)	Annual	2
Hearing Aids	One per ear one (1) time every three (3) years	
Home Health Services	Annual	20 Visits
Hospice Care	Lifetime	90 Days
Inpatient Hospital Services	Annual	30 Days
Mental/Nervous Disorders		
Inpatient	Annual	10 Days
Outpatient		24 Visits
PET Scans	Annual	2 Each
Nutritional and Weight Counseling	Annual	2 Visits
Outpatient Occupational & Physical Therapy (Combined Benefit)	Annual	30 Visits
Outpatient Speech Therapy	Annual	10 Visits
Organ Transplant Benefits	Lifetime	1 Transplant***
Custom Molded Foot Orthotics	Annual	2 Pairs
Diabetic Related Footwear/Shoes	Annual	2 Pairs
Prosthetic Bra for Oncology Covered Members	Annual	2 Each
Wound Care and Hyperbaric Oxygen Treatment	Annual	20 Visits

**These services will be covered exclusively through the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program (MPS-AQIP). All services must be pre-authorized and must be performed at a MPS-AQIP designated Treatment Center. For more information call 888-295-3591.*

***Services must be rendered at MHBF Chemical Dependency Treatment Center to be covered. For details regarding this benefit, call 888-295-3591.*

****Transplants must be performed at MHBF Designated Transplant Centers to be covered. For more information call 888-295-3591.*

Preventative Care/Wellness Benefits

The Plan will pay 100% of the reasonable and customary charges for Preventative Care. For services to be considered under this benefit, the Provider's claim must designate a Preventative Diagnosis and CPT Code only.

Physician Evaluation and Consultation Visit Copayment

$20.00 each visit for Current Procedural Terminology Codes 99201 through 99215

The Physician Visit Copayment will not count toward your Calendar Year Deductible and any services or procedures rendered other than the CPT codes listed above will be reimbursed as outlined in the Fund Booklet.

Major Medical Deductibles

Standard Individual Calendar Year Major Medical	$500, $1,200, or $2,000
Family Deductible Maximum	$6,000

Emergency Ambulance Services (ground or air ambulance)

Annual 2 each per year

Individual Coinsurance

The covered individual pays coinsurance for the first $20,000 of Arkansas In-State, In-Network Provider covered expenses after the calendar year deductible(s). Once the covered individual meets the Arkansas In-State, In-Network coinsurance maximum, the Plan will reimburse 100 percent of all covered Arkansas In-State, In-Network services for the remainder of the calendar year.

The covered family pays coinsurance for the first $40,000 of Arkansas In-State, In-Network Provider covered expenses after the calendar year deductible(s). Once the covered family meets the Arkansas In-State, In-Network coinsurance maximum, the Plan will reimburse 100 percent of all covered Arkansas In-State, In-Network services for the remainder of the calendar year.

The Stop Loss provision does not apply to non-emergent Out-of-State In-Network or Non-PPO provider services and the individual will be responsible for coinsurance for all covered expenses from Out-of-State In-Network or Non-PPO providers. Emergency Room copayments (access fees) assessed are not included within the Stop Loss provision.

After the calendar year deductible(s) are met, the Plan will pay the following percentages:

	PPO	Non-PPO
Emergency Room Services	80%	80% of the Plan's Usual & Customary Allowables for PPO Services
PPO Providers (In-State or Out-of-State)	80%	
Non-PPO Providers (In-State or Out-of-State) (Except for Emergency Room Charges)		50% of the Plan's Usual & Customary Allowables for Non-PPO Services (See Usual and Customary Charges under Definitions)

Emergency Room Services

Outpatient Emergency Room visits will require a $250 copayment (access fee) made by the covered member for each visit. This $250 copayment is in addition to any other Plan deductible or copayment requirement. Emergency Room copayments do not apply to the Plan deductible or towards the coinsurance maximum. When an emergency room visit results in inpatient hospital admittance (excluding observation stays), the $250 emergency room copayment will be waived. However, this does not apply when you are admitted to a different hospital than where you received emergency services. Non-PPO emergency room services will be reimbursed at the same PPO deductible requirements and benefit percentages for emergent and immediate care only and up to the Plan's reasonable and customary allowables for such services.

Prescription Drugs

Prescription drug benefits are covered through the Prescription Drug Card Program. Member copayments are outlined below (per 30 day supply; limit of 90 day supply per fill).

Restat's Align Program is specifically designed to offer affordable benefits while managing the benefit costs as a whole. As part of Restat's Align Program, covered members will be able to save on generic and specific OTC medications at specific pharmacy locations. Where you shop matters:

Prescription Copayment Structure:

Pharmacy Type	Day Supply	OTC	Generic	Preferred Brand	Non-Preferred Brand
Align Pharmacies	**30 days**	**$0**	**$4**	**$30**	**$50**
All Other Pharmacies (retail*/mail)	30 days	$5*	$10	$30	$50
Specialty Pharmacy	30 days	If the cost of Medication is: • between $0.01 and $1,000.00 = $50 copayment • greater than $1,000.01 = $100 copayment			

To locate a Restat Pharmacy go to www.restat.com > For Members > Pharmacy Locator, enter your address or zip code. You can then toggle between the Align pharmacies or National network.

Dental Care Coverage Maximums and Deductible

Dental Procedures	Annual	$1,200
Orthodontic	Lifetime	$1,000
Temporomandibular Joint Dysfunction (TMJ)	Annual	$1,000
Dental Care Deductible	Annual	$50

Routine Vision Care and Deductible

Routine Exam, Eye Glasses, Contact Lenses	Annual	$150
Routine Vision Care Deductible		$50

Life and AD&D Benefits

Please consult your Employer to determine the amount of your Life and AD&D Benefits.

Disability Income Benefits

Some employers have an accident and illness income benefit that the Municipal Health Benefit Fund administers. Please consult your Employer to determine if your group coverage includes Disability Income Benefits.

Important Disclaimer

The information presented in this Fund Booklet is not a guarantee of payment. All benefits described are subject to all Plan policy provisions, limitations, filing deadlines, exclusions and eligibility requirements.

Explanation of Benefits and Benefit Limitations

Stop Loss for Major Medical

When In-State, In-Network covered charges reach $20,000 for the covered individual or $40,000 for the covered family and the calendar year deductible(s) are met, the Plan will pay 100 percent of all covered services above that amount for the remainder of the calendar year, unless excluded or modified by other portions of this benefit booklet. This is called a Stop Loss Provision. Out-of-State In-Network Provider and Non-PPO provider charges do not count toward the Stop Loss Maximum(s) and the Plan will not pay 100 percent of Out-of-State In-Network Provider and Non-PPO provider charges. In addition, penalty deductible(s) and the Emergency Room Services copayments do not count toward the Stop Loss Maximum(s). The Plan will not pay 100 percent of the Emergency Room Service charges unless the copayment is waived due to inpatient hospital admission.

Preferred Provider Network (PPO) for Major Medical, Dental and Vision Care

In an effort to better control costs and provide quality service, the Plan is participating in a managed care concept. The concept encourages the employees and their dependents to use physicians, hospitals and other providers that have agreed to join the Network of Preferred Providers. The Municipal Health Benefit Fund has developed and maintains its own Preferred Provider Network. You may choose to use a PPO provider or a non-PPO provider. The Plan will pay a higher benefit if you choose to use a PPO provider. It will be the member's responsibility to inquire whether a provider is in the PPO Network. Your personal identification card will notify the provider of your membership in the Plan.

Directories listing hospitals and providers for medical, dental and vision services, who have agreed to handle billing and collections for the patient and follow the Utilization Review Program of the Plan, are available through your employer. The Provider Directory, as well as a list of participating pharmacies, is also available on the League's website at www.arml.org.

Calendar Year Deductibles for Major Medical, Vision and Dental Care

Medical—A Calendar Year Deductible of $500, $1,200 or $2,000 (please consult your Employer for the amount of your deductible) shall be applied to the amount of covered medical expenses that are incurred each calendar year. Each covered member shall satisfy the $500, $1,200 or $2,000 calendar year deductible up to a Family Maximum Deductible of $6,000, if and when the covered member(s) incurs and submits covered medical expenses in an amount equal to the deductible.

Dental—a $50 Calendar Year Deductible will be applied to the amount of covered dental expenses that are incurred each calendar year. Each covered member will satisfy the Calendar Year Deductible, if and when the covered member incurs and submits covered dental expenses in an amount equal to the deductible.

Routine Vision—a $50 Calendar Year Deductible will be applied to the amount of covered vision expenses that are incurred each calendar year. Each covered member will satisfy the calendar year deductible, if and when the covered member incurs and submits covered vision expenses in an amount equal to the deductible. (See Precertification, Penalty Deductibles and Utilization Review for Medical Vision information.)

Precertification, Penalty Deductibles and Utilization Review

It is the member's responsibility to precertify by calling 888-295-3591. A $1,500 penalty deductible will be assessed for failure to precertify any services requiring precertification, per occurrence.

- Ambulatory Surgical Procedures (whether they are performed in a Hospital, Ambulatory Surgery Center or doctor's office)
- Bariatric Weight Loss Program
- Chemical Dependency Treatment
- Durable Medical Equipment (if purchase price or annual rental cost exceeds $2,000)
- Home Health Care Services (care in a home setting)
- Hospice Care
- Inpatient Hospital Confinements
- Organ Transplant Services
- Outpatient Observation lasting more than 23 hours (all outpatient stays lasting more than 24 hours will be reimbursed as Inpatient Confinements, and/or charges will be reduced to 23 hours of observation)
- PET Scans
- Prosthetic Devices (if purchase price exceeds $2,000)
- Wound Care & Hyperbaric Oxygen Treatments

Elective Surgical Procedures — Annual Maximum of 2

(Hospital or Ambulatory Surgery Center)

For a comprehensive list of elective surgical procedures, please call 888-295-3591. Members are allowed a yearly maximum of two procedures.

Please call 888-295-3591 anytime to verify if precertification will be needed.

Utilization Review Program

The Municipal Health Benefit Fund has adopted a Utilization Review Program. In certain cases, the Review Program requires certification prior to treatment, as well as concurrent review, discharge planning, cost effectiveness and medical case management. A $1,500 penalty deductible will be assessed for failure to precertify with the Review Program where the Plan requires precertification.

Once a service has been precertified, the services must be rendered within 30 days of the date it was precertified. If the services are not rendered within the 30 day time period, the precertification process must be started again.

You or your doctor must precertify by calling the Utilization Review Program at 888-295-3591. The ultimate responsibility to precertify rests with the covered member.

Inpatient Admission

You must notify the Utilization Review Program of a scheduled admission prior to the date of service. As soon as you know you will be hospitalized, you or your physician must precertify your care by calling the Utilization Review Program at 888-295-3591. Inform the Utilization Review Program that you are covered under the Municipal Health Benefit Fund and provide the Program with your doctor's name and telephone number. Failure to notify the Utilization Review Program prior to admission will result in the assessment of a $1,500 penalty deductible.

If your admission is due to an emergency, you will have until 5:00 p.m. the next business day to notify Utilization Review of that admission. Direct admissions from your physician's office are not considered emergencies and must be precertified by you or your physician. Failure to do so will result in the assessment of $1,500 penalty deductible.

Outpatient observations lasting more than 23 hours may be considered as an inpatient admission and/or reduced to the 23-hour observation limit. No benefits will be paid for any charges related to non-certified days or services.

Surgical Procedures

Precertification is required for surgical procedures regardless of where they are performed.

PET Scans

Precertification is required for all PET Scans.

Hospice and Home Health Care

Hospice and care provided in a home setting also require precertification.

Durable Medical Equipment and Prosthetic Devices

Standard durable medical equipment purchases and rental and purchases of prosthetic devices retailing $2,000 or higher must be precertified. See the topic Rental of Durable Medical Equipment under Covered Medical Charges.

Exception for Childbirth

The Plan does not restrict the duration of hospital stay for the mother or newborn child up to a stay of 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. The Utilization Review Program must be notified for stays in excess of 48 hours or 96 hours at 888-295-3591.

Important Information

If the Utilization Review Program disagrees with the number of days recommended by the doctor, or the use of durable equipment, you and your doctor will be advised. The Plan will not pay for treatment which is not approved by the Utilization Review Program. If you disagree with any payment decision, you may appeal. The decision to accept treatment is between you and your provider.

Medically Necessary means services or charges submitted to the Plan must meet the conditions of being medically necessary to be considered for payment. The Plan will generally consider care of treatment to be medically necessary if:

- It is consistent with the patient's medical condition or accepted standards of good medical practice;
- It is medically proven to be effective treatment of the condition; and
- It is the most appropriate level of service(s) which can be safely provided to the patient.

Only your medical condition is considered in determining whether the level of care or type of health care facility is appropriate. Neither your financial status nor family situation, the distance from a facility, patient or physician convenience, nor any other non-medical factor is considered in the determination of medical necessity.

Services and supplies which are not medically necessary are not covered, except for preventative health services for which coverage is listed herein. Hospitalization that is extended for reasons other than medical necessity, i.e., lack of transportation, lack of caregiver at home, inclement weather and other social reasons not justifying coverage for extended Hospital care is not covered.

Additionally, medically necessary standards apply to all covered benefits outlined in the Plan. If Utilization Review determines that a service is not medically necessary before or after a participating PPO Provider renders it, we prohibit the Provider who rendered the service from billing you for those services, UNLESS you agreed in writing to be responsible for payment before the services were rendered. Charges for services or supplies rendered by non-PPO Providers that are not considered medically necessary by the Utilization Review Program will be the responsibility of the member receiving the services.

Any appeal as to medical necessity will be referred to a Medical Reviewer designated by the Plan Administrator. **The decision of the Plan Administrator's Medical Reviewer shall be final and binding to all parties.**

The Plan will not pay for services or supplies furnished after the date your coverage ends, even if the Municipal Health Benefit Fund precertifies or provides benefit information for a treatment plan submitted before the end of your coverage.

Special Benefits

Case Management

Case Management should be utilized by the member of the Plan where services with high expenses are expected or where such services are expected but are not available within the Preferred Provider Network. The Case Manager will work with the member and provider to seek out a cost-effective approach to the illness or injury as described in the Utilization Review Program portion of this booklet.

In an effort to reduce recurring visits to a hospital setting, Alternative Case Management may be recommended. Benefits may be extended, based on the recommendation of the Case Manager if such recommendation would tend to provide for physician-approved treatment outside the hospital setting. Alternative Case Management may be considered if medical expenses are expected to exceed the Plan's defined maximum for a specific benefit. Alternative Case Management will normally include, but will not be limited to, durable medical equipment, home health and hospice, inpatient and outpatient therapy.

At the sole option of the Plan Administrator, alternative benefits may be provided by the Plan in lieu of Major Medical Expense benefits. Alternative benefits shall be provided if, in the sole discretion of the Plan Administrator, such services are feasible, cost-effective, medically necessary and available in your locale. The Case Manager will have the ability to recommend a treatment plan above the annual benefit maximum. This benefit will not exceed $5,000 in a calendar year. Eligible Case Management charges will be paid using the Plan's percentage reimbursements.

Preventative Care Program/Wellness Program

Annual Exam Benefits

The following annual benefits are reimbursable at 100 percent of allowable, subject to usual, reasonable and customary charges and are not subject to deductibles and benefit percentages. To be considered under the following benefits, the provider's bill must designate a routine wellness diagnosis code only. Claims received with diagnoses other than or in addition to routine wellness will be considered under the Major Medical Benefits and reimbursed accordingly.

- Mammogram — one (1) per calendar year
- PAP Screening — one (1) per calendar year
- PSA (Prostate Specific Antigen test) — one (1) per calendar year
- Colon-Rectal examination — Coverage for medically-recognized screening examination for the detection of colorectal cancer for covered individuals who are fifty (50) years of age or older or for covered individuals who are less than fifty (<50) years of age that have a family or personal history and at normal risk for developing colon polyps or colon cancer for Eligible Benefits incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. This includes annual fecal occult blood tests and a colonoscopy and/or flexible sigmoidoscopy (examination of the large intestine) performed every five (5) years with a family or personal history of colon polyps, colon cancer or a colonoscopy performed every ten (10) years. This Benefit excludes coverage for virtual colonoscopies. This benefit will include routine and diagnostic colon-rectal examinations.
- General Health Panel
- TB
- Chest X-Ray (front and lateral)
- Well Baby Care/Well Child Care
- Carotid Screening

Immunizations/Inoculations

- DT (Diphtheria and Tetanus Toxoids)
- DtaP Diphtheria, Tetanus Toxoids and Pertussis
- Td (Tetanus) booster
- MMR (Measles, Mumps, Rubella)
- MMR booster
- Poliomyelitis Vaccine
- Oral Polio
- Varicella Vaccine (Chicken Pox)
- Influenza
- Hepatitis A
- Hepatitis B
- Pneumococcal (Pneumonia)
- Pediarix (Diphtheria and Tetanus Toxoids and Acellular Pertussis Absorbed, Hepatitis B [Recombinant] and Inactivated Poliovirus Vaccine Combined)
- HIB (Hemophilus Influenza B)
- HPV (Genital Human Papillomavirus)
- Rotovirus
- Zosatavax (Shingles Vaccine)

Please note: Allergy injections and expenses related to routine newborn care are not considered part of this benefit. Other injectable medicines may be covered under the Drug Card Program. Please see the Prescription Drug Card section of this booklet. Pharmacy copays will be assessed if the above are administered at your local pharmacy, except for Influenza.

Healthy Lifestyle/Informational Only

The biometric and health information below is to assist you in determining your healthy lifestyle goals with your doctor.

✓ Heart Rate	Beats/Minute	60-80
✓ Blood Pressure:	Normal	Less than 120/80
	Pre-hypertension	120-139/80-89
	Hypertension Stage 1	140-159/90-99
	Hypertension Stage 2	159/99
✓ Body Mass Index	BMI	19% -24%
✓ Lipid Profile Cholesterol	Desirable	Less than 200
	Borderline High	200-239
	High	Greater than 240
✓ Total Cholesterol Ratio	(TC divided by HDL)	Less than or equal to 4.5
✓ LDL Cholesterol (Bad)	Optimal	Less than 100
	Near Optimal	100-129
	Borderline High	130-159
	High	160-189
	Very High	Greater than 189
✓ HDL Cholesterol (Good)	Low	40
	Desirable	40-59
	High	Greater than 59
✓ Triglycerides	Normal	Less than 150
	Borderline High	150-199
	High	200-499
	Very High	Greater than 500

- ✓ Comprehensive Metabolic Blood Panel includes: Glucose, Diabetes, Calcium, Sodium, Potassium, CO2, Chloride, Urea Nitrogen BUN, Creatinine, Albumin, Bilirubin, Phosphatase Alkaline, Protein, Transferase Alanine Amino (ALT)(SGPT), Transferase, Aspartate Amino (AST)(SGOT)
- ✓ Thyroid Stimulating Hormone (TSH) tests the thyroid gland for over/under thyroid for women age 36 and over
- ✓ Osteoporosis Screening for bone density for women age 51 and over
- ✓ Mammogram one (1) per calendar year is recommended for women age 41 and over
- ✓ Well Woman Check Up/PAP one (1) per calendar year is recommended for women age 36 to age 51
- ✓ Prostate Specific Antigen (PSA) which tests for prostate cancer and benign prostate enlargement is recommended for men age 51 and older
- ✓ Fecal Occult Blood Test is recommended for everyone age 41 and older

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eDocAmerica gives you email access to physicians, psychologists, pharmacists, dentists, dietitians, and fitness trainers:

Ask whatever you want, whenever you want, and get personal answers. When you log in to your eDocAmerica account, you can choose who you want to contact. There are no fees or copays of any kind. With eDocAmerica you and your immediate family have unlimited access to your very own medical team. Physician answers are guaranteed in 24hrs with most responses arriving within 2-3 hours.

Telephone access to the eDocAmerica medical team:

With eDocVoice you can access our medical team through our telephonic platform. Call the phone number and record your question. Once the medical team has answered your question, the system will automatically call you back and play their response. No Internet needed.

Healthy Lifestyle/Informational Only, continued

iPhone App and Droid App:

The era of Smartphones is here and eDocAmerica is bringing our team of medical experts directly to your hand-held device. Download the free app and get the personal medical attention you need for your on-the-go life. Want to send in a picture? Use the camera on your phone and attach the picture directly to your question. The App will also allow you access to your eDocVoice number, nurse line number, weekly health tips, and more.

24 hour Registered Nurse Advice Line:

The nurse line is available 24 hours per day, 7 days per week and 365 days per year. At the start of each call the caller is offered the opportunity to communicate in either English or Spanish.

The registered nurse will advise the caller as to the proper disposition for his/her stated medical concern or problem. These dispositions will range from home care advice to recommended emergency care immediately.

The 24/7 Registered Nurse Advice Line is available at 866-842-5365 or you may call eDoc at 866-525-3362 for assistance.

Additional included services:

eDocAmerica users enjoy a physician-written weekly Health Tip delivered right to your email, a Health Risk Assessment that helps you gain a snapshot of your current health status, a 3D Video Library with access to 250+ medical topics, and more. Take a moment to log in to your eDocAmerica account and scroll through the icons to see the additional services included in your account.

Covered Major Medical Charges

Covered Medical Charges include only the charges and fees described below that (a) are not excluded by other provisions applicable to these benefits, (b) are medically necessary for the care and treatment of illness or injury of a covered member, (c) are recommended by an attending physician, (d) do not exceed the usual, customary and reasonable charges as determined by the Plan in accordance with health care industry standards for the area in which the services and supplies are furnished, and (e) are deemed necessary by the Utilization Review Program. A charge is considered to be incurred on the date a covered member receives the services or supplies for which the charge is made. (For more information see Medically Necessary under Important Information on page 14.)

Accident Related Dental Charges—Dental charges are not covered under Major Medical Benefits except for the prompt repair of sound natural teeth or other body tissues required as a result of accidental injury sustained while covered. Treatment must start within 30 days and be completed within six months. Any injury to teeth while eating is not covered in this provision.

Ambulance Services (Ground and Air)—Charges for emergent medically necessary local transportation of a covered member by a professional ambulance company to and from a hospital will be covered under the per occurrence maximums of the Plan, being two each per year.

Anesthesia Charges—For the administration of anesthesia when not included in Hospital or Ambulatory Surgery Center charges.

Cataract Surgery—Charges for cataract surgery, including the first pair of standard eyeglasses or standard contact lenses if needed as a result of cataract surgery, when purchased within ninety (90) days of the cataract surgery. Lenses and glasses will be reimbursed under the usual and customary fees allowed by the Plan.

Emergency Room Charges—Charges for medically necessary emergency room services.

Family Planning—Benefits are provided for an elective vasectomy performed only in a physician's office. The Plan will also provide benefits for an elective tubal ligation.

Inpatient Hospital Charges—the Plan will pay up to a maximum of 30 days per year for covered room and board and other necessary services and supplies, unless defined elsewhere in this booklet. In-Hospital Room accommodations covered are: semi-private room (two or more beds), approved intensive and cardiac care units and private room. if you choose to have a private room, you will be responsible for the difference between the hospital's charge for an average semi-private room and its private room charge. If the hospital is an all-private room facility, the Plan will consider 90 percent of the private room charge as the covered charge.

Medical Supplies and Pharmaceutical Charges—The Plan will pay for up to a thirty (30) day supply for medical supplies and pharmaceutical charges prescribed by a medical doctor for the treatment of a medical condition, including but not limited to diabetic and insulin supplies, unless defined otherwise under the Drug Card Benefit.

Physicians' Fees—For medical care and treatment other than the performance of surgical procedures. For more information, please see Usual, Customary and Reasonable Charges (UCR).

Prosthetic/Orthotic Devices—When ordered by a physician, coverage is provided for prosthetic devices such as orthopedic braces, custom built shoes or supports, internal fixation (such as hip pinnings), internal prostheses, and replacement of artificial legs, arms and eyes. Also included is the replacement of these devices when required by a change in your physical condition, as well as repairs to prosthetic devices. Precertification is required for purchase of all prosthetic/orthotic devices that exceed $2,000. Coverage for replacement of a prosthetic or orthotic device may, at a minimum, be one (1) time every three (3) years, unless it is medically necessary as indicated by medical criteria. However, these devices will not be covered if they are misused or lost. (See Exclusions.)

Radiological and Laboratory Charges—For radiological examinations and diagnostic laboratory services.

Rental or Purchase of Durable Medical Equipment—The Plan will pay for standard durable medical equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home. Additionally, the Plan will replace standard durable medical equipment that is no longer serviceable provided it meets the criteria above. The Plan will not pay for air conditioners, dehumidifiers, humidifiers, air purifiers, waterbeds, car seats, whirlpools, spas, exercise equipment, motorized or other specialty or customized equipment, nor for service and/or maintenance contracts and agreements for durable medical equipment. Durable medical equipment, such as a standard hospital bed, standard wheelchair, etc., must be prescribed by a physician and must be required for temporary therapeutic use. If a member must rent durable medical equipment for an extended period of time, the Plan reserves the right to pay for the rental monthly, not to exceed the purchase price. If an item of durable medical equipment is not available for purchase, the Plan reserves the right to establish a rental or purchase price based on the reasonable and customary charge for such equipment. The Plan will never pay more than the purchase price for any durable medical equipment.

Precertification is required when any durable medical equipment is purchased, rented or leased if the retail purchase price or annual rental cost will exceed $2,000. Benefits will not be considered until the Utilization Review Program has precertified and/or certified the equipment.

Surgeons' Fees—For the performance of surgical procedures by a physician. Pre-op and post-op care is paid for when the surgeon bills under the global surgical CPT (Current Procedural Technology) coding rules.

Covered Medical Charges with Special Limitations on Specific Types of Medical Treatments

Acute Inpatient Rehabilitation—Payment for this benefit is limited to a maximum of 30 days per illness or incident, but not to exceed the annual inpatient hospital maximum benefit. Payment is limited to acute rehabilitation as prescribed by a physician and is subject to review by Case Management to identify medical criteria and cost effective alternatives.

Sub-acute Inpatient Rehabilitation—Payment for this benefit is limited to a maximum of 15 days per illness or incident, but not to exceed the annual inpatient hospital maximum benefit. Payment is limited to sub-acute rehabilitation services as prescribed by a physician and is subject to review by Case Management to identify medical criteria and cost effective alternatives.

Bariatric Weight Loss Program

Bariatric Weight Loss Program*—MHBF will provide coverage for bariatric surgery to include:

a. Adjustable gastric banding surgery

b. Gastric Bypass surgery

c. Sleeve Gastrectomy surgery or

d. Duodenal switch biliopancreatic diversion.

A pre-determination is required in order to proceed with the Notification Review and is required to review the eligibility for a surgical procedure. To qualify to be eligible requires documentation of six (6) consecutive months of physician-supervised weight management program that may include but is not limited to nutritional education and a physical activity program. The covered individual, treating physician or family member must provide information for the Medical Care Management pre-determination review. Failure to do so will result in no benefit coverage for morbid obesity services.

Eligible Morbid Obesity expenses incurred will be covered subject to Medical Case Management approval and Plan limitations. Under this provision, Morbid Obesity includes the pre-obesity evaluation, medical and surgical treatment for post obesity follow-up care including but not limited to treatment of any complications. The Morbid Obesity treatment must be performed at a Plan-Designated Morbid Obesity Treatment Center and is an eligible benefit for covered individuals nineteen (19) years of age or older.

Non-Covered Nutrition—The Plan will not cover food, shakes, vitamins or any supplements regardless of who prescribed or recommended them.

Non-Designated Morbid Obesity Center—If the Morbid Obesity treatment is performed at a Non-Designated Morbid Obesity Treatment Center or if Medical Case Management is refused, the pre-obesity, obesity and post obesity care will not be covered.

Disqualification from Program—If a covered member does not follow the guidelines as instructed by Case Management and/or the Bariatric Surgeon and is disqualified for any reason from this program, they must wait until the next Plan Year to re-qualify.

Claims Consideration—All claims related to MBS-AQIP must have the pre-determination or pre-authorization number on each claim to be considered for payment.

Any Obesity related charges for services not rendered under this program will not be covered by the Plan. Furthermore, Morbid Obesity treatment procedures will not be paid if the procedure is an Experimental and Investigative Medical Procedure as defined in this booklet.

How to Obtain a Pre-Determination

1. Call your MHBF nurse case manager at 888-295-3591 and notify them that you are interested in the MPS-AQIP program.
2. Once pre-determination is completed the member will then contact the MBS-AQIP physician's office for program registration. This must be done at www.obesity-surgery.net. You must fill out the new patient application online.
3. After the application is completed and you have been approved for the program, you will then complete 6 months of physician supervised weight management.
4. Monthly updates are required to be sent to the MHBF nurse case manager by your physician or dietician.

How to Obtain Pre-Authorization for Bariatric Surgery

1. Call your MHBF case manager and notify them that you have completed the 6 months of physician supervised weight management and are ready to proceed with surgery.

2. Your case manager will contact the MBS-AQIP physician's office and proceed with prior-authorization.

The Plan criteria used for prior-authorization can be obtained by contacting your MHBF Nurse Case Manager at 888-295-3591.

**These services will be covered exclusively through the Metabolic & Bariatric Surgery Accreditation & Quality Improvement Program (MBS-AQIP). All services require a pre-determination and a pre-authorization. Retro Determination or Retro Authorizations will not be considered. Participation in this program must be performed at a MBS-AQIP designated Treatment Center.*

Chiropractic Services—Are covered only for an eligible member five (5) years and older. Payment for covered services performed by a Chiropractor, including visits, adjustments and other covered charges, is limited to 12 visits per calendar year. Please note that Temporomandibular Joint Dysfunction (TMJ) is not a covered benefit under Chiropractic Services. TMJ is addressed under the Dental Benefits provisions of the Plan.

Diabetic Education or Training—The Plan will allow for a one day Diabetic Education or Training session per calendar year. However, if there is significant change in the covered member's condition or symptoms making it medically necessary to change the covered member's diabetic management process, the Plan will allow for an additional one day Diabetic Education or Training session. The additional Diabetic or Training session must be prescribed by a physician.

Enteral Feeds (tube feeding)—The Plan will cover enteral feeds when it is the member's only means of nutrition.

Hearing Aids—The Plan will pay up to a maximum of $1,400 per ear one (1) time every three (3) years for hearing aids, including the repair and replacement parts that are designed and offered for the purpose of:

- Aiding a person with or compensating for impaired hearing;
- Is worn on or in the body;
- Is generally not useful to a person in the absence of a hearing impairment; and
- Is sold by a professional licensed by the state to dispense a hearing aid or hearing instrument.

Individual coinsurance and the individual annual deductible will not be applied to the hearing aid benefit; however, any out of pocket costs associated with these devices will not be credited toward the individual annual deductible. Additionally, these devices will not be covered if they are misused or lost. (See Exclusions.)

Important Information

All charges and/or costs above the $1,400 maximum per ear one (1) time every three (3) years will be the member's responsibility.

Chemical Dependency Treatment—These services are limited to one treatment plan per lifetime. Services must be rendered at the MHBF Chemical Dependency Treatment Center to be covered. You must contact MHBF Case Management at 888-295-3591 who will direct your care and precertify services. No benefits will be available for Chemical Dependency services performed at any facility which is not designated by the Plan. An order by a court or state agency for psychiatric treatment is not an indication of eligibility under this benefit.

Home Health Care Services (care performed in a home setting)—Payment of these benefits is limited to an annual maximum of 20 visits per year and is subject to review by Case Management to identify medical criteria and cost effective alternatives. Coverage for this benefit will be limited to charges for Home Health Care visits made by a Registered Nurse, a Licensed Practical Nurse, a Physical Therapist, an Occupational Therapist or a Speech Therapist and in accordance with a home health care plan established by a doctor and/or recommended by Case Management. You must be homebound to qualify for Home Health Care Services. (See Definitions.)

Covered Medical Charges with Special Limitations, etc., continued

Hospice Care—The Plan will pay for covered Hospice charges, whether in the home or in an inpatient setting, including equipment and supplies, which are medically necessary for treatment if the member is totally disabled as a result of terminal illness and has a life expectancy of six months or less. A treatment plan is required and must be submitted to Case Management for precertification before benefits can be considered. Hospice Care charges will be limited to a lifetime maximum of 90 days. (Please see Alternative Case Management for additional information.)

Maternity Benefits and Newborn Child Care—Maternity benefits will be effective when the date of conception follows the effective date of the member's coverage. Newborn baby care will be covered provided dependent coverage is in effect at the time of delivery. The Plan's annual inpatient hospital maximum applies to this benefit.

Mental and Nervous Disorders—Payment for services incurred in connection with treatment of mental illness or functional nervous disorders, is limited to a maximum of 10 inpatient days per calendar year, with 24 physician visits per calendar year for inpatient and outpatient charges. These payments are not eligible for the Stop Loss Provision. (See Exclusions for further information.)

Organ Transplant Benefit Charges—Transplant benefits are all inclusive and limited to 1 per lifetime. All inclusive means all charges for all services for an organ transplant, including but not limited to, testing prior to transplant and all post-operative treatment. Additionally, donor procurement, tissue typing, surgical procedure, along with storage and transportation costs are included in the annual benefit but must be billed inclusively under the covered member of the Fund to be considered. Eligible procedures are: heart, lung, liver, kidney, pancreas, cornea and bone marrow.

All transplants must be performed at one of the MHBF Designated Transplant Centers to be covered. You must contact MHBF Case Management at 888-295-3591 who will direct your care and precertify services. No benefits will be available for transplants performed at any facility which is not designated by the Plan.

Physical Therapy and Occupational Therapy Services (Outpatient Clinical Setting) — Therapy services will be combined to allow for an annual maximum of 30 visits for Physical Therapy or Occupational Therapy. The services of a Licensed or Registered Physical Therapist or Licensed Occupational Therapist are covered if the treatment meets all of the following:

- Is part of a documented treatment plan;
- Is medically necessary;
- Is for a condition that is the result of a disease or injury; and
- Is not excluded elsewhere in the policy;
- Is prescribed by a licensed physician.

Speech Therapy Charges—Speech therapy benefits will be provided where speech has already existed and when speech therapy is used to restore speech when the loss is due to a disease or injury. When speech loss is due to disease or injury, the Plan will pay benefits for the following services of a doctor or speech pathologist if the speech therapy program is prescribed by and under the supervision of a doctor: (a) Diagnostic services to determine the extent of the loss or impairment of the patient's ability to speak; and (b) rehabilitative services to restore or improve the patient's ability to speak. There will be an annual maximum of 10 Outpatient Speech Therapy visits per year.

Wound Care and Hyperbaric Oxygen Treatment—The total number of one-hour sessions for hyperbaric oxygen therapy and/or the total number of treatments received in an outpatient Wound Care facility will be limited to a maximum of 20 per year provided the treatment is for a condition that is covered under the Plan and is prescribed by and administered under the direct supervision of a licensed physician.

Health Care Exclusions

General Information—The Plan does not pay benefits for exclusions and health care services and items not specifically described within this booklet, even if the following is true:

- It is recommended or prescribed by a physician;
- It is the only available treatment for your condition;
- Was a covered benefit in previous Plan years; or
- Items that are misused or lost.

No benefits are payable for charges a covered member is not required to pay or which would not be made if coverage did not exist.

Abortion—The Plan will not cover an elective abortion, nor will charges for medical services, supplies or treatments utilized to cause an elective abortion be considered. Charges for supplies or treatment provided arising from medical complications of an elective abortion will not be covered.

Acupuncture—Any service or charge associated with Acupuncture treatment, regardless of the provider performing the services.

Against Medical Advice—The Plan will not cover any services required for complications arising out of the member's discharge from care contrary to medical advice.

Alcohol Consumption—Health care or services for the treatment of injuries and/or injury-related diseases, brought about in whole or in part, by the member's use or misuse of alcohol, including, but not limited to, driving or operating a motor vehicle as defined by the laws of the jurisdiction in which the vehicle or other device was being driven or operated.

Alcoholism and Related Diseases—Health care or services for the treatment of alcoholism and other alcohol related diseases, unless defined elsewhere in this booklet.

Benefits Outside the United States—Services and supplies including, but not limited to drugs, office visits, surgical centers and/or treatments and diagnostic procedures received in or out of a hospital setting outside the United States of America are not covered under the Plan. However, charges may be submitted for possible benefit consideration at the sole discretion of the Plan Administrator.

Breast Reduction or Augmentation Procedures—Services and procedures to reduce or augment breast size, with the exception of breast cancer, will not be covered by the Plan.

Benign Gynocomastia (abnormal breast enlargement in males)—Services and procedures to treat this condition will not be covered by the Plan.

Blood—Blood, blood plasma, blood derivatives as these can be donated or replaced by the member or family. Additionally, fees to cover blood donations or blood storage are not covered.

Convalescent Care—Any service or charges associated with convalescent, residential treatment, custodial or sanitarium care unless defined elsewhere in this booklet.

Cosmetic—Cosmetic procedures, surgery, services, equipment or supplies, provided in connection to elective cosmetic or reconstructive surgery, including, but not limited to reconstruction of the jaw to improve dental alignment or bite, or any complications related to a previous cosmetic surgery or procedure unless incurred as a result of (1) an accidental injury sustained while covered under this Plan or (2) for the reconstruction of both breasts due to cancer.

Counseling Services—Outpatient counseling services (marriage, family, career, children, social adjustment, pastoral, financial or any form of group counseling) will not be covered by the Plan, unless defined elsewhere in this booklet.

Diagnostic Cardiac Catheterizations—Coverage for Cardiac Catheterizations in environments where cardiac interventions cannot be performed.

Health Care Exclusions, continued

Deductible(s), Copayment(s) or Coinsurance—Services that are reimbursable under any other Municipal Health Benefit Plan provisions or charges that are applied to the Plan's deductible, coinsurance or copayment provisions.

Dental—Care or treatment of teeth, gums or alveolar process, except as a result of accidental injury as defined under Medical benefits in this Plan. Any injury to teeth while eating is not covered. (See Dental Coverage for related coverages.)

Developmental Delay—Services or treatments for mental or physical behavioral or learning disabilities and/or developmental delays, except as covered under the Mental Health provisions of the Plan.

Domestic Partners—The Plan does not provide coverage for domestic partners of the same sex or opposite sex.

Durable Medical Equipment—Charges for misuse or loss of durable medical equipment will not be covered by the Plan.

Eating Disorders—Anorexia Nervosa, Bulimia and services related to eating disorders are not covered, except as covered under the Mental Health provisions of the Plan.

Education or Training—Testing or training performed for educational purposes, including play therapies and therapies for persons with behavioral or learning disabilities and/or developmental delays, except as covered under the Mental Health provisions of the Plan.

Exercise—Any routine exercise or wellness programs unless specifically provided for by the Plan.

Genetic Testing or Services—Testing or measurements of biochemical markers as a diagnostic or screening technique and the services of geneticists or genetic counselors are not covered under the Plan with the exception of cancer screening.

Growth Deficiencies or Abnormalities—Testing and treatment for growth deficiencies/abnormalities except when medically necessary due to pituitary gland removal.

Hearing—Charges for misuse or loss of hearing aid devices will not be covered by the Plan.

Hyperhidrosis—Surgical treatment of Hyperhidrosis is not a covered benefit under the Plan.

IDET Procedures—Intra-Discal Electro-thermal Therapy (IDET) or similar procedures or any complications arising out of these types of procedures.

Illegal Act—Health care or services for the treatment of injuries occurring in the course of or in the furtherance of the member's commission of acts contrary to federal, state or local law.

Immediate Relative—Services or charges provided by someone who is an immediate relative as defined in the Definitions section of this booklet or who ordinarily resides in your home.

Infertility—Any service associated with testing or treatment for infertility, in vitro fertilization or artificial insemination.

Injuries by Third Parties—Treatment or services for any illness or injury for which a third party is liable or legally responsible.

Late Charges—Charges for late payments and/or penalties submitted by a provider. The Plan will not pay 100 percent of a provider's billed charges in these instances.

Long-Term Care—Long-Term Care is not a covered benefit under the Plan.

Maintenance Care—All services, equipment and supplies which are provided solely to maintain a covered individual's condition and from which no functional improvement can be expected or is not life sustaining treatment for a medical condition.

Mandated or Court Ordered Care—Coverage for medical, psychological, or psychiatric care required by court order, or otherwise mandated by a third party, are not covered by the Plan.

Medication Maintenance Agreements—The Plan will not cover testing for drug compliance of members seeking treatment for pain management under these types of agreements with their physicians/providers.

Midwifery—services and providers of midwifery are not covered under the Plan. Additionally, any complications associated with services provided under this exclusion will not be covered.

Missed or Cancelled Appointments—Charges for missed or cancelled medical, dental or vision appointments.

Muscle Therapy—Any service performed by masseurs, masseuses or for massages.

Never Events—A list of events compiled by the National Quality Forum and Medicare and defined as adverse non-reimbursable reportable events/conditions which are considered unacceptable and eminently preventable.

Obesity or Weight Reduction—Charges for services and/ or over the counter and prescription drugs for the treatment of obesity and/or weight reduction, except as outlined under the Bariatric Weight Loss Program.

Orthotripsy—Extracorporeal Shock Wave Therapy is not a covered benefit under the Plan.

Penile Implants and Erectile Pumps—Charges incurred for any services or procedures related to penile implants and pumps will not be covered by the Plan.

Preexisting Conditions Ages 19 Years and Older—Treatment of conditions, illnesses or injuries existing prior to the effective date of your coverage until your coverage has been in effect for a period of at least six (6) consecutive months will not be covered for members 19 years old and older. In other words, if you have a medical problem at the time your coverage is effective and you seek treatment for that medical problem within the first six months after the effective date of the coverage, the Plan will not be obligated to pay for such treatments. The Plan will consider a condition, injury or disease to have existed, if, during the six (6) consecutive months prior to the effective date of your coverage you have knowledge of a condition, illness or injury that would ordinarily cause a reasonable person to:

- Seek out professional advice; or
- Receive treatment; or
- Seek to be diagnosed; or
- Be given care; or
- Have medication prescribed for the condition, illness or injury.

Periods of creditable coverage, as defined in applicable regulations and law, will exempt the member from the preexisting exclusion period. The Municipal Health Benefit Fund will accept Certificates of Creditable Coverage provided by the member's prior health plans and/or health insurers in these instances.

Prescription Drugs—Refer to the Prescription Drug Coverage section of the booklet for exclusions and limitations pertaining to prescription drugs.

Records—Charges for medical records, photocopying or related charges for materials necessary to determine the Plan liability or claim.

Routine Foot Care—The Plan does not cover any services or supplies in connection with:

a. Care of corns or calluses;
b. Care of toenails;
c. Care of flat feet;
d. Supportive devices of the foot such as arch supports and/or pelvic or spinal stabilizers;
e. Orthotics for sports use.

Prosthetic/Orthotic Devices—Charges for misuse or loss of prosthetic or orthotic devices will not be covered by the Plan.

Service and Maintenance Contracts—Any contract for service and/or maintenance for durable medical equipment.

Sex Change—Charges for or related to sex change or any treatment of gender identity.

Sexual—Reversals of elective vasectomies or elective tubal ligations are not covered.

Health Care Exclusions, continued

Substance Abuse and Related Diseases—Health care or services for treatment of substance abuse or related diseases brought about in whole or in part by the member's use or misuse of either legal or illegal substances. Nor will payment be made for health care or services for the treatment of traumatic injuries brought about in whole or in part by the member's use or misuse of either legal or illegal drugs.

Surrogate Pregnancy—Any services or charges associated with Surrogate Pregnancy.

Tattooing—Any service or charges associated with tattooing for any reason will not be covered by the Plan.

TMJ—Temporomandibular joint dysfunction and related procedures by whatever name called, diagnosis and/or treatment even when deemed medically necessary, unless defined otherwise under the Dental section of this Plan.

Travel Related Medical Services—Medical services and immunizations to fulfill requirements for international travel.

Unproven Medical Procedures/Treatment—Any medical procedure or drug that falls under any of the following:

a. Not consistent with standards of good medical practice in the United States as evidenced by endorsement by national guidelines (such as those prepared by the NIH and/or NCCN);
b. Under study in clinical trials other than as the control arm of a randomized phase III/IV trial for the specific illness;
c. Exceeds (in scope, duration or intensity) that level of care which is needed; or
d. Are given primarily for the personal comfort or convenience of the patient, the family, or the provider.

Vision—Eye refractions, eyeglasses, contact lenses, or the fitting of such items or exercises for the eyes, and charges for eye surgery to correct refractive errors including radial keratotomy (RK), photo refractive keratotomy (PRK), automated lamellar keratoplasty (ALK), Lasik or any related kerato-refractive surgery to correct refractive error. See Vision Care coverage section of this Plan for covered services.

Vitamins—Over-the-counter vitamins and/or nutritional supplements.

Voluntary Exposure to Danger—Participation in nontraditional sports, activities and adventure sports engaged in for leisure, recreation, competition, entertainment or monetary purposes. Nontraditional sports, activities and adventure sports typically involve a high level of inherent danger such as but not limited to activities involving speed, height, high levels of physical exertion, highly specialized gear, spectacular stunts involving a higher number of inherently uncontrollable variables than traditional activities with pronounced risk-taking allowing and encouraging individual creativity in the innovation of new maneuvers and in the stylish execution of existing techniques requiring control of risk.

War—Any health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion extends to services for treatment of military service-related disabilities when you are legally entitled to other coverage.

Work Rehabilitation—Work-hardening programs or performance-oriented therapy using graded and sequential advancement of activities simulating work situations, task ergonomics and proper body mechanics to rehabilitate patients for a return to work.

Work Related—Injuries and illness arising out of or in the course of any employment for compensation or profit even if coverage under worker's compensation or similar legislation is optional and the member chooses not to elect such coverage.

****Please note:** that medical complications occurring as a result of receiving services excluded under the Plan, including but not limited to, surgeries, procedures, or medications, are not covered by the Plan. For other policy provisions, explanation of services and limitations, please see Definitions beginning on "Definitions" on page 54.

Prescription Drug Coverage

General Coverage

Prescription Drug Charges—for drugs and medicines obtainable only on a physician's written prescription, except as defined under Drug Card Quantity Limitations.

- Prescription/Medical ID cards should be delivered within 30 days from the date the Plan has received and processed your enrollment paper work.
- Coordination of Benefits Rules do not apply to the Drug Card Program.
- Copayments do not go toward any deductible(s) or Stop Loss provisions.

Prescription Drug Card Program—Municipal Health Benefit Fund program members will be provided with an ID Medical/Drug card that can be used in most drug stores in the state and nationwide. Member copayments are outlined below (per up to a 30-day supply)

Type of Drug Copayment

Pharmacy Type	Day Supply	OTC	Generic	Preferred Brand	Non-Preferred Brand
Align Pharmacies	30 days	$0	$4	$30	$50
All Other Pharmacies (retail*/mail)	30 days	$5*	$10	$30	$50

To locate a Restat Pharmacy go to www.restat.com > For Members > Pharmacy Locator, enter your address or zip code. You can then toggle between the Align pharmacies or National network.

How can you take advantage of Align program savings?

If you currently purchase your prescriptions at one of the Align pharmacies listed:	If you currently do not use an Align pharmacy:
Simply present your new Municipal Health Benefit Fund Medical/Prescription ID card. You will automatically be charged the lower generic copay.	Switch to an Align pharmacy. Call the pharmacy or bring your current prescription packaging to the Align pharmacy of your choice.

If you have any questions regarding your prescription drug plan, please feel free to contact Restat's Customer Service Center at **855-253-0846**.

Covered OTC products at retail pharmacies (with written prescription):

Anti Ulcer Medications (including generics)

- Axid AR
- Pepcid AC OTC
- Prevacid OTC
- Prilosec OTC
- Tagamet HB OTC
- Zantac-150 OTC
- Zegerid OTC

Non and Low Sedating Antihistamines (including generics)

- Allegra OTC
- Allegra D OTC
- Claritin OTC
- Claritin D OTC
- Zyrtec OTC
- Zyrtec-D OTC

Prescription Drug Coverage, continued

Obtaining Benefits for Covered OTC Products—A written prescription is required for these OTC (over-the-counter) products. Once this is obtained, simply present the prescription and your Medical/Drug ID card to your retail pharmacy. The purchase will be processed in the same manner as a prescription drug purchase is processed.

Brands with a Generic Available—A brand with a generic available is a product for which a therapeutically equivalent generic alternative is available. Most brand drugs with generics available are considered non-preferred products and will collect the non-preferred brand copayment. The copayment applies regardless of whether the member or the physician chooses the product.

Covered Prescriptions—Injectable and non-injectable drugs requiring a prescription, except as specifically excluded, are considered covered.

Contraceptive Coverage—The Municipal Health Benefit Fund will provide coverage for contraceptive products to its members through a closed drug formulary. The spectrum of products covered will represent the therapeutic sub-classes as established in the clinical literature. While the list is subject to change, every effort will be made to adequately communicate changes with fund participants. The contraceptive list may be found at www.restat.com > For Clients > Contraceptive List

Blood Glucose Monitoring Program—Blood glucose meters allow diabetic members to become an active participant in the management of their diabetes by allowing them to detect and treat changes in their blood sugar. In an effort to help diabetic members effectively self manage their diabetes. Restat has created a blood glucose monitoring program that allows diabetic members to receive a free blood glucose meter kit at no charge.

How the Blood Glucose Monitoring Program Works—When the member places an order they will receive a free glucose meter kit shipped directly to the address of their choice within two to four weeks. The kit contains everything the member needs to begin testing their blood sugar-a meter, test strips, lancet device, lancets, and user's manual.

It's important to provide the correct order code and company name when requesting a free meter, refer to the chart below for details.

The following Accu-Chek and OneTouch blood glucose meter kits are currently available:

LifeScan Inc., a Johnson & Johnson company	Roche Diagnostics
ONETOUCH® UltraMiniTM Meter Just the basics of testing. ONETOUCH® Ultra®2 Meter See how food affects your blood glucose.	ACCU-CHEK® Aviva system (Meter includes the ACCU-CHEK Connect tool kit guide and video)
COMPANY NAME: RESTAT ORDER CODE: 574RET001 ONLINE ORDER: www.onetouch.orderpoints.com TOLL FREE NUMBER: 1-800-991-2652	COMPANY NAME: RESTAT ORDER CODE: RESTAT11 ONLINE ORDER: meters.accu-chek.com TOLL FREE NUMBER: 1-888-355-4242

Free Diabetic Supplies—You will receive a $0 copayment on your diabetic supplies when purchased within 100 days of your insulin or diabetic medication. The pharmacy must process the prescription for your insulin or diabetic medication before processing the supplies.

How the Tobacco Cessation Program Works—members who wish to discontinue their tobacco and participate in this program must obtain the appropriate prescriptions from their physician. The following medications will be covered for up to one 90-day period per calendar year. These medications include:

Product	Limit	Copayment
Transdermal nicotine patch	Up to a 30-day supply per fill	$50.00 per 30-day supply
Nicotine gum	Up to a 30-day supply per fill	$50.00 per 30-day supply
Nicotine lozenge	Up to a 30-day supply per fill	$50.00 per 30-day supply
Nicotine inhaler	Up to a 30-day supply per fill	$50.00 per 30-day supply
Nicotine nasal spray	Up to a 30-day supply per fill	$50.00 per 30-day supply
Chantix	Up to a 30-day supply per fill	$50.00 per 30-day supply

Although the above-named nicotine-containing products are over-the-counter (OTC), the member must obtain a prescription for these products from their physician in order to be covered by the program. All of these products will require prior authorization. The member's physician must contact the Evidence-Based Prescription Drug program (EBRx) at UAMS at (866) 785-7935 in order to request authorization.

Medicare Retirees and Medicare Eligible Members (MEDICARE PART B & PART D)

Medicare Retirees and those Medicare Eligible Members whose primary insurance is Medicare must purchase their diabetic supplies under Medicare Part B. It is required that you have your pharmacy electronically bill Medicare as primary and then bill MHBF/Restat as secondary. If you purchase your diabetic supplies within 100 days of your insulin or diabetic medication – you will have a $0 copayment on your supplies.

Mail-Order Pharmacy—In addition to the traditional retail pharmacy network, plan members may obtain their medications through **MedVantx** mail order pharmacy. The mail order copayment structure is the same as that for retail. Information and instructions on how to use the mail order pharmacy may be obtained by calling **MedVantx at (866) 744-0621** or by visiting www.MedVantxRx.com. The Plan's standard copayment structure will apply to each 30-day supply of medication obtained through the mail service pharmacy. A maximum of a 90-day supply of medication may be obtained through the mail service pharmacy, however a copayment for each one month supply will be charged.

Specialty Pharmacy—Very expensive medications (many of which are injectables) are covered under the prescription drug card benefit. However, due to the extreme cost of these products, they will be covered through a specialty pharmacy provider, Allcare Specialty Pharmacy. The Evidence-Based Prescription Drug program (EBRx) at UAMS will need to be contacted for prior authorization by calling **(866) 785-7935.** If approved, the authorization will be referred to Allcare Specialty Pharmacy. The member or physician will then be contacted to arrange for shipment of the medication.

The member will also be provided instructions on how to obtain subsequent refills, when authorized by the physician. Specialty medications are limited to a maximum of 30 days per prescription.

Complete list of Specialty medications is available at www.restat.com > For Clients > Specialty Pharmacy

Allcare Specialty Pharmacy (refills): (855) 780-5500

Specialty Pharmacy Copayment: If the total cost of the medication is between $0.01 and $1000.00, the member will be responsible for a $50 copayment; if the total cost of the medication is over $1000.01, the member will be responsible for $100 copayment.

Drug Therapy Management Programs

In an effort to ensure that prescription coverage remains affordable for MHBF members, it is necessary to employ a variety of Drug Therapy Management Programs for covered drugs. These programs help reduce unsafe usage and costly medication waste as well as encourage cost-effective drug therapy. Brief descriptions of these programs, along with effected drugs, are provided below.

Dosing Guidelines / Quantity Limitations—Dosage guidelines or quantity limits are employed by the plan to ensure safe and effective drug usage. These guidelines are consistent with the FDA-approved labeling and limit the amount of a particular medication that can be dispensed (1) per prescription, (2) per day, or (3) per timeframe. A listing of drugs managed by quantity limits is provided below.

Drug Category Drugs Limitations / Notes

***Antidepressant Drugs*—**Celexa, Effexor, Lexapro, Paxil, Prozac, Wellbutrin, Zoloft, etc.

***Antipsychotic Drugs*—**Abilify, Geodon, Risperdal, Zyprexa, etc.

***ADHD Drugs*—**Adderall, Concerta, Focalin, Metadate, Ritalin, etc.

Anti-Nauseant Drugs—Anzemet, Emend, Kytril, Zofran—Limit: 5-day supply per prescription

Anti-Migraine Drugs—Axert, Amerge, Frova, Imitrex, Maxalt, Sumatriptan, Relpax, Zomig, Migranal (Each product has a defined 30-day limit per prescription)

Narcotic Analgesics—Duragesic Patches Limit: 10 patches per 30 days; Oxycontin Limit: 2 tablets per day

Sedatives / Hypnotics—Ambien, Ambien CR, Edluar, Lunesta, Sonata—Limit: 30 units per 30 days

***Asthma Inhalers*—**Advair, Aerobid, Alvesco, Azmacort, Dulera, Flovent, Pulmicort, QVAR, Spiriva, Symbicort —1 inhaler per 30 days

Cholesterol Medications—Altoprev, Crestor, Lescol, Lipitor, Mevacor, Pravachol, Vytorin, Zetia, Zocor—30 tabs/30 days

Osteoporosis Drugs—Actonel, Atelvia, Boniva, Fosamax

NOTE: Drugs may be added to the plan's quantity limit list throughout the year without notice.

Step / Contingent Therapy

Step Therapy is designed to manage drug therapy in a "stepped" fashion where the most cost-effective drugs are tried before other and more expensive therapies can be used. It is important to understand that Step Therapy does not promote or require the use of inferior drug products and is not based solely on cost. In many situations, the newest and most heavily promoted drugs lack documented evidence that they are better than older and less expensive drugs. Therefore, Step Therapy will allow "step 2" drugs to be covered contingent upon (1) the prior use of a "step 1" drug or (2) presence or absence of a particular diagnosis or circumstance. A listing of drugs/drug categories affected by Step Therapy is provided below.

NOTE: Drugs may be added to the plan's Step Therapy list throughout the year without notice.

Drug Category	Step-2 or Target Drugs	Step-1 Drugs or Contingencies
Antidepressant Drugs	Cymbalta, Effexor XR	Generic SSRI Antidepressants—citalopram, escitalopram, fluoxetine, paroxetine, sertraline
Anti-Asthmatic Drugs	Advair, Arcapta, Symbicort, Serevent, Foradil, Perforomist, Brovana, Dulera	Inhaled steroid
Anti-Diabetic Drugs	Byetta, Victoza	Prior or concurrent antidiabetic drug use
Anti-Diabetic Drugs	Symlin	Prior or concurrent insulin use
Anti-Diabetic Drugs	Januvia, Janumet, Janumet XR, Jentadueto, Juvisync, Kombiglyze, Onglyza, Tradjenta	Prior use of 1st-line antidiabetic agents
Anti-Inflammatory Biologic Agents	Actemra, Amevive, Cimzia, Enbrel, Kineret, Orencia, Remicade, Rituxan, Simponi, Stelara, Tysabri	Humira

Reference Pricing

Reference Pricing is applied to drug classes where little to no clinical difference exists among drugs in the class, but where significant differences exist in cost. Based on published clinical evidence, MHBF will select the Best-In-Class or Reference Drug for each drug class involved in Reference Pricing. The amount paid by MHBF per tablet or capsule for the Reference Drug will be the amount MHBF will pay for all other drugs in the same class. The member will be able to obtain a prescription for the Reference Drug for the plan's standard copayment amount. For all other drugs in the same category, the member will pay the difference between the Total Cost of the drug being dispensed and the cost of the Reference Drug. This copayment can be substantial.

Members are encouraged to ask their doctor for a Reference Drug when appropriate in order to save money.

NOTE: Drugs and drug categories may be added to the plan's reference pricing list throughout the year without notice.

Drug Category	Reference Drug(s)	Non-Reference Drugs
Stomach Ulcer / Reflux Drugs	Prilosec OTC, omeprazole, pantoprazole, Prevacid OTC, Zegerid OTC	Aciphex, Dexilant, (formerly Kapidex), Duexis, lansoprazole, Nexium, Prevacid, Prilosec Rx, Protonix, Vimovo, Zegerid Rx Capsules
High Blood Pressure Drugs	**Any generic ACE Inhibitor (including diuretic combinations):** (benazepril, captopril, enalapril, fosinopril, lisinopril, moexepril, perindopril, ramipril, quinapril, trandolapril) **Any generic ARB (including diuretic combinations):** (losartan, irbesartan, eprosartan)	**All brand-name ACE Inhibitors (including diuretic combinations):** Accupril, Aceon, Altace, Capoten, Lotensin, Mavik, Monopril, Prinivil, Univasc, Vasotec, Zestril **All brand-name ARB Agents and Direct Renin Inhibitors (including diuretic combinations):** Atacand, Avapro, Benicar, Cozaar, Diovan, Edarbi, Micardis, Tekturna, Teveten **Other brand-name combination Agents:** Amturnide, Azor, Exforge, Tekamlo, Tribenzor, Twynsta, Valturna
Lipid-Lowering Drugs (statins)	Atorvastatin, simvastatin, lovastatin, pravastatin	Caduet, Crestor, Lescol/XL (brand), Lipitor (brand), Livalo, Mevacor (brand), Pravachol (brand), Simcor, Vytorin, Zocor (brand)
Lipid-Lowering Drugs (triglyceride agents)	Fenofibrate	Antara, Fenoglide, Fibricor, fenofibrate, fenofibric, Lipofen, Lofibra, Lopid, Tricor, Triglide, or Trilipix
Sleep Drugs	Zolpidem, zaleplon	Ambien, Ambien CR, Edluar, Intermezzo, Lunesta, Rozerem, Silenor, Sonata, zolpidem ER, Zolpimist
Antihistamines / Allergy Drugs	Allegra / Allegra-D OTC Claritin / Claritin-D OTC Zyrtec / Zyrtec-D OTC	Clarinex (brand), Xyzal (brand)
Nasal Steroids	Fluticasone, flunisolide	Beconase/AQ, Flonase (brand), Nasacort/AQ, Nasalide, Nasarel, Nasonex, Omnaris, QNasl, Rhinocort/AQ, triamcinolone, Veramyst, Zetonna
Muscle Relaxants	Generic products (baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, methocarbamol, tizanidine, etc.)	Amrix, Fexmid, Flexeril (brand), Lioresal (brand), metaxalone, Lorzone, Norflex (brand), Robaxin (brand), Soma (brand), Skelaxin (brand and generic), Zanaflex
Misc. Antibiotics	Doxycycline, minocycline, amoxicillin	Adoxa, Doryx, Monodox, Oracea (doxycycline), Solodyne (minocycline), Moxatag (amoxicillin)
Analgesics / Anti-Inflammatory / Pain Agents	Tramadol, diclofenac	Celebrex, Conzip, diclofenac ER, Flector Patch, Lazanda, Naprelan, Pennsaid, Ryzolt, Rybix ODT, Solaraze, Sprix Nasal Spray, Subsys, Ultram ER, Ultracet (tramadol), Zipsor (diclofenac)
Migraine Drugs	Sumatriptan, naratriptan, Maxalt	Amerge, Axert, Frova, Relpax, Treximet, Zomig
Overactive Bladder Drugs	Oxybutynin immediate-release	Detrol/LA, Ditropan XL, Enablex, Gelnique, Sanctura, Toviaz, Vesicare, Oxytrol Patches, oxybutynin ER
Testosterone Products	Injectable Testosterone	Androderm, Androgel, Axiron, First Testosterone Cream/Oint., Fortesta, Striant, Testim, Testoderm, Testopel
Osteoporosis Agents	Alendronate	Actonel, Atelvia, Boniva (brand and generic), Fosamax / D, Ibandronate

Prescription Drug Coverage, continued

NOTE: A helpful "Reference Pricing Guide" is included below to assist you and your physician in selecting the appropriate drug product for you.

Municipal Health Benefit Fund - Prescription Drug Program
Reference Pricing Guide

If you are taking:	You may want to ask your doctor for:
Lipid Lowering Drugs—Statins	
Caduet, Crestor, Lescol/XL (brand), Lipitor (brand), Livalo, Mevacor (brand), Pravachol (brand), Simcor, Vytorin, Zocor (brand)	*Atorvastatin, simvastatin, lovastatin, pravastatin*
Lipid Lowering Drugs—Triglyceride Agents	
Antara, Fenoglide, Fibricor, fenofibrate, fenofibric, Lipofen, Lofibra, Lopid, Tricor, Triglide, or Trilipix	*fenofibrate* (generic Tricor)
High Blood Pressure Drugs	
Accupril/Accuretic, Aceon, Altace, Amturnide, Atacand/HCT, Avapro/Avalide, Azor, Benicar/HCT, Capoten/Capozide, Cozaar/Hyzaar, Diovan/HCT, Edarbi/Edarbyclor, Exforge, Lotensin/HCT, Mavik, Micardis/HCT, Monopril/HCT, Prinivil/Prinzide, Tekamlo, Tekturna/HCT, Teveten/HCT, Tribenzor, Twynsta, Univasc/Uniretic, Valturna, Vasotec/Vaseretic, Zestril/Zestoretic	***Generic ACE Inhibitors:*** *Benazepril/HCT, captopril/HCT, enalapril/HCT, fosinopril/HCT, lisinopril/HCT, moexepril/HCT, perindopril, ramipril, quinapril/HCT, trandolapril,* ***Generic ARB Agents:*** *losartan/HCT, irbesartan, eprosartan*
Migraine Drugs	
Amerge (brand), Axert, Frova, Imitrex (brand), Relpax, Treximet, Zomig, or Zomig ZMT	*sumatriptan* (generic Imitrex), *naratriptan* (generic Amerge), Maxalt
Sleep Drugs	
Ambien, Ambien CR, Edluar, Intermezzo, Lunesta, Rozerem, Silenor, Sonata, zolpidem ER, Zolpimist	Zolpidem immediate release (generic Ambien), *zaleplon* (generic Sonata)
Overactive Bladder Drugs	
Detrol, Detrol LA, Ditropan (brand), Ditropan XL, Enablex, Gelnique, Oxytrol Patches, Sanctura, Toviaz, Vesicare	*oxybutynin immediate release* (generic Ditropan)
Muscle Relaxants	
Generic products (*baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, methocarbamol, tizanidine,* etc.)	Amrix, Fexmid, Flexeril (brand), Lioresal (brand), metaxalone, Lorzone, Norflex (brand), Robaxin (brand), Soma (brand), Skelaxin (brand and generic), Zanaflex
Stomach Ulcer / Reflux Drugs	
Aciphex, Dexilant, Duexis, *lansoprazole*, Nexium, Prevacid Rx, Prilosec (brand), Protonix, Vimovo, Zegerid Rx	*omeprazole, pantoprazole*, Prevacid OTC, Prilosec OTC, Zegerid OTC
Antihistamines / Allergy Drugs	
Clarinex, Clarinex-D, Xyzal	Allegra / Allegra-D OTC, Cetirizine/cetirizine-D (generic Zyrtec/Zyrtec-D OTC), loratadine/loratadine-D (generic Claritin/Claritin-D OTC)
Nasal Steroids	
Beconase/AQ, Flonase, Nasacort/AQ, Nasalide, Nasarel, Nasonex, Omnaris, Qnasl, Rhinocort/AQ, Veramyst, Zetonna	fluticasone (generic Flonase), flunisolide

If you are taking:	You may want to ask your doctor for:
Analgesics / Anti-Inflammatory / Pain Agents	
Celebrex, Conzip, *diclofenac ER*, Flector Patch, Lazanda, Naprelan, Pennsaid, Ryzolt, Rybix ODT, Solaraze, Sprix Nasal Spray, Subsys, Ultram ER, Ultracet (tramadol), Zipsor (diclofenac)	Tramadol immediate release, diclofenac immediate release, naproxen (most other generic NSAIDs)
Testosterone Products	
Androderm, Androgel, Axiron, First Testosterone Cream/ Oint., Fortesta, Striant, Testim, Testoderm, Testopel	Injectable testosterone
Osteoporosis Drugs	
Actonel, Atelvia, Boniva (brand and generic), Fosamax, Fosamax-D, *Ibandronate*	*alendronate* (generic Fosamax)

In order to save out-of-pocket cost by reducing your copayment, you may want to contact your doctor to see if one of the drugs listed in the right-hand column would be right for you.

Prior Authorization

To ensure appropriate medication use, it is sometimes necessary to require prior authorization for some medications. Consideration for coverage will be given for those medications listed below. ***Your doctor must contact the University of Arkansas College of Pharmacy (UAMS), Evidence-Based Prescription Drug Program (EBRx) to provide justification for the use of the medication***. The partial list of medications requiring prior authorization is below:

- All Specialty / Biotech Medications
  (complete list provided at www.restat.com > For Clients > Specialty Pharmacy)
- Lidoderm Patches
- Nuvigil
- Provigil
- Uloric
- Zyvox
- Transdermal nicotine patch
- Nicotine gum
- Nicotine lozenge
- Nicotine inhaler
- Nicotine nasal spray
- Chantix

If the total cost of the medication is greater than $2,500.00 at the retail pharmacy or over $7,500.00 at the mail order pharmacy, the prescription will require Prior Authorization. Please contact EBRx at **(866) 785-7935**.

Provider Assistance (Physicians and Pharmacists only)

The University of Arkansas College of Pharmacy, Evidence-Based Prescription Drug Program (EBRx), will handle the prior authorization management for selected medications and will address questions from providers (physicians and pharmacists) pertaining to these drugs. EBRx's hours of operation are Monday-Friday, 9:00 a.m.-5:00 p.m. CST. Your physician or pharmacist may obtain EBRx's contact information by calling the ***EBRx*** call center at **(866) 785-7935**.

Note: All Member calls must be directed to the Restat call center at (855) 253-0846 available 24/7.

Drug Card Exclusions

The products or drug categories listed below are excluded from coverage under the prescription drug program but may be reimbursed under major medical portion of the plan:

- Contraceptive Devices & Implants
- Miscellaneous Medical Supplies
- Nutritional / Dietary Drugs
- Anabolic Steroids
- Growth Hormones
- Anorexiants
- Appetite Suppressants
- Anti-Obesity Drugs
- Smoking Cessation Drugs (unless otherwise specified)
- Anti-Abuse Drugs
- Cosmetic Agents
- Erectile Dysfunction Drugs
- Experimental or Investigational Drugs
- Over-The-Counter medications (unless otherwise specified)
- Misc. Cough and Cold products
- Misc. Dermatological products

New Drugs Entering the Market—All new drugs entering the market will automatically be excluded from coverage. These drugs will remain excluded until evaluated by the Pharmacy and Therapeutics Committee. If this committee, made up of practicing physicians and pharmacists, determines that a product should be covered, it will then be moved to the appropriate preferred or non-preferred copay tier on the formulary. Otherwise, it will remain excluded from coverage.

Prescription Coverage for Members and Their Dependents who have Medicare as Their Primary Coverage.

A benefit is provided by the Municipal Health Benefit Fund to supplement Medicare Part D prescription drug coverage. Enrollment for Medicare Part D coverage is required in order to be eligible for this benefit supplement.

The supplement pays benefits toward out-of-pocket costs for expenses eligible under Medicare Part D that are also eligible under the provisions of Prescription Drug Coverage of the Municipal Health Benefit Fund for Employees and Dependents. Your out-of-pocket cost for these expenses, after the combined benefits, is no more than the plan copays.

Steps to Receive Medicare Part D Benefits:

- Enroll in a Medicare Part D Plan that you select, and pay the monthly premium;
- Instruct the pharmacist to submit the prescription drug expense to your Medicare D Plan as the primary carrier and then submit to Restat as the secondary carrier;
- You pay only the plan copayments for that medication.

Important Note:

If the pharmacy cannot coordinate benefits, submit a Prescription Drug Claim Form (available at www.arml.org) to:

Restat
Patient Reimbursement
11900 W. Lake Park Drive
Milwaukee, WI 53224

Attach copies of prescription receipts showing the following information:

- Pharmacy Name and Address
- Patient Name
- Prescription Number
- Fill Date
- Drug Name and Strength
- Quantity & Days supply
- Drug Cost and the amount Paid.

Please allow 4-6 weeks for processing.

Status of these claims can be obtained by calling the Restat Call Center at (855) 253-0846.

Dental Benefits

Benefits Payable—These benefits are payable if a covered member incurs dental expenses and has satisfied the Dental Calendar Year Deductible of $50 for the year in which the expenses are incurred. Benefits are payable in an amount equal to the appropriate Covered Percentage of such expenses as set out in the Schedule of Benefits. However, the total amount payable for all Covered Dental Charges incurred by a covered member during a calendar year will not exceed the Annual Maximum of $1,200 unless defined otherwise in the Schedule of Benefits.

Covered Dental Charges—Include only those charges for reasonable and necessary dental services and supplies as described below that are received by a covered member directly on account of dental treatment necessitated by dental disease, defect or injury to teeth and which (a) are not included by other provisions applicable to these benefits and (b) do not exceed the usual and customary charges within the area for the services and supplies furnished:

- Oral examinations, including prophylaxis, but not more than two examinations in any calendar year.
- Topical application of sodium or stannous fluoride and the application of sealants.
- Dental X-rays.
- Fillings, extractions, space maintainers and oral surgery.
- Anesthetics administered in connection with covered dental services.
- Injection of antibiotic drugs by the attending dentist.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment, including root canal therapy.
- Repair or re-cementing of crowns, inlays, bridgework or relining or repair of dentures.
- Initial installation (including adjustments for the six-month period following installation) of partial or full removable dentures to replace one or more natural teeth extracted while covered under these provisions.
- Replacement of an existing partial, or fully removable denture(s), or fixed bridgework by a new denture, or new bridgework, including crowns and inlays forming the abutments for replacement of teeth, two or more years after the effective date of the covered member's benefits, or the addition of teeth to an existing partial removable denture, or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Plan Administrator is presented that:
  a. The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement; or
  b. The existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the immediate denture; or
  c. The replacement or addition of teeth is required to replace one or more additional natural teeth, extracted while covered under these provisions and after the existing denture or bridge work was installed.
- Inlays, gold fillings, crowns (including precision attachments for dentures) and initial installation of fixed bridgework (including inlays and crowns to form abutment) to replace one or more natural teeth extracted while covered under these provisions.
- Orthodontic treatment, including correction of malocclusion. However, the total amount of benefits payable for all such expenses incurred will not exceed the maximum benefit of $1,000 for orthodontic treatments, even if required as a part of a medical procedure. Orthodontic benefits are not payable under the TMJ provisions of the Plan.
- Temporomandibular Joint Dysfunctions (TMJ)—Payment for services for the treatment of TMJ is limited to $1,000 per calendar year. The calendar year limit will include services for facial or joint pain related to temporomandibular joint dysfunction. This limit applies to TMJ services, even if treatment is related to a medical condition, and is covered only under the Dental Benefit. TMJ benefits are not payable under the Orthodontic provisions of the Plan.

Dental Exclusions

No benefits are payable for charges a covered member is not required to pay or which would not be made if benefits did not exist, or for expenses incurred:

- On account of or in connection with:
  a. The replacement of a lost or stolen prosthetic device.
  b. Charges made by a provider other than a dentist, or charges for treatment by a provider other than a dentist, except for a prophylaxis, if otherwise covered by these benefits, which may also be performed by a licensed dental hygienist working under the supervision of a dentist.
  c. Prosthetic devices (including bridges, crowns and appliances) and the fitting thereof which were ordered for an individual prior to his becoming covered under these provisions.

- For care, treatment, services and supplies:
  To the extent that, in the absence of these benefits, they are covered expenses reimbursable in full or in part under this Plan.
  a. Furnished primarily for cosmetic purposes.
  b. Provided by someone who is an immediate relative as defined in the "Definitions" sections of this booklet or who ordinarily resides in your home.

Vision Care Benefits

Benefits Payable—Vision benefits are payable up to an amount of $150 if a covered member incurs covered vision expenses in a calendar year in excess of a $50 vision calendar year deductible.

Covered Vision Expense—Covered Vision Expenses are charges for necessary vision care as listed below:

- Eye examinations by Optometrist or Ophthalmologist.
- The purchase of eyeglasses, tints, coatings, and contact lenses as a result of an examination for which a benefit is payable.

Medical Eye Care—Eye disease and other medical treatment of the eye will be covered under the major medical care provision for service provided by an Optometrist or Ophthalmologist. (See Precertification, Penalty Deductibles and Utilization Review for further information.)

Vision Care Limitations

Vision Care provisions are subject to the Health Benefit Fund General limitations. In addition, expenses due to the following are not Covered Vision Expenses:

a. Examination, lenses or frames received in or from an institution owned or operated by the federal government where there is no obligation to pay in the absence of coverage.
b. Sun glasses.
c. Repair to frames.

Additional Dental and Vision Provisions—The Exclusions provision of the Hospital or Major Medical Expense Benefits will, to the extent not inconsistent, also apply to these benefits. These benifits do not apply to adult dependents age 19 through 26.

Life Coverage

Life Benefits—If a death occurs while covered under the Plan, the amount of Life benefits will be payable as described below:

Employee	Consult your Employer for amount
Spouse	$5,000
Child by Age at Death 2 weeks	Nil
2 weeks but less than 6 months	$200
6 months but less than 19 years	$2,000
19 years or over	Nil

Life benefits cease when coverage terminates, members go on retired status or go on COBRA.

Payment of Claim—Upon receipt by the Plan at its office of due written proof of claims for either employee or dependent, such amount will be promptly paid to you or your beneficiary, if living at the time payment is made. Otherwise, such amount will be paid in a single sum to the estate of the deceased.

Accidental Death and Dismemberment Benefits
A separate certificate outlines your benefits for Accidental Death and Dismemberment that are underwritten by an insurance company. Consult your Employer for amount of benefit.

Disability Income Benefits

Optional Coverage for Full-Time Employees Only

Each group has the option to enroll in the disability income benefit. Check with your Employer to see if you are covered.

Benefits Payable—Benefits are payable in the amount and for the period of time stated below based on the appropriate Weekly Benefit, Maximum Number of Weeks, and First Benefit Day. These benefits are payable if, while covered and as a result of illness or injury, you become totally disabled to the extent that you are completely and continuously prevented from performing any and every duty which your Employer may offer you, are under the direct care of a physician, are not engaged in any other work for compensation or profit, including self employment and a physician determines that you are totally disabled. The Plan reserves the right to request a determination of disability by a physician selected by the Plan. This benefit is not assignable.

Option A (26 Week Benefit)	
Weekly Benefit	$105
First Benefit Day for Disability due to Accident	1st Day
Illness	8th Day
Maximum Number of Weeks Payable	26 Weeks

Option B (52 Week Benefit)	
Weekly Benefit	$105
First Benefit Day for Disability due to Accident	183rd Day
Illness	183rd Day
Maximum Number of Weeks Payable	52 Weeks

Weekly Benefits are payable from the First Benefit Day of any one continuous period of disability up to the appropriate Maximum Number of Weeks. One seventh of the Weekly Benefit is payable for each full day of covered disability but no benefit is payable for part of a day. Successive periods of disability, separated by less than two consecutive weeks of continuous full-time work with the Employer, will be considered one continuous period of disability unless the later disability is due to an unrelated cause, and begins after return to full-time work with the Employer for at least one full day.

Filing a Claim—For a covered member to file a disability claim, he or she should contact their Employer to obtain a Request for Disability Income Form. The requested forms must be submitted and received by the Plan Administrator within 180 days of the first date of disability. The Disability Income Form is also available online at www.arml.org.

Disability Income Benefits Exclusions—Disability payments will not be made unless you are under the continuous care of a physician, or for any disability due to intentionally self-inflicted injury, or for any disability due to injury or illness arising out of or in the course of any employment for compensation or profit. The Exclusions provision of the Hospital or Major Medical Expense Benefits will, to the extent not inconsistent, also apply to these benefits. Prescription drug card or managed care prescription plan copayments will not be reimbursed under the Coordination of Benefits provision, except for Medicare Part D.

Section 3, Coordination of Benefits

Coordination of Benefits (COB)

You or your family members may have coverage under more than one health plan. This Plan contains a coordination of benefits provision which eliminates duplication of payment for services received while covered under this Plan. The benefits payable under this Plan for medical, dental or vision expenses will be coordinated with group insurance and health benefit plans providing benefits for such expenses to cover up to 100 percent of Allowable Expenses incurred, after the deductible has been satisfied. Benefits payable under the Plan will also be coordinated with applicable medical payment coverages, including, but not limited to, auto* and homeowners coverages. The Municipal Health Benefit Fund will follow the usual rules of coordination of benefits.

***Please note:** For covered members who decline to purchase the minimum medical coverage under their auto insurance, the Municipal Health Benefit Fund will coordinate as if the covered member had purchased this coverage.

Integration of Benefits

Integration of benefits applies when a covered person is receiving benefits for medical expenses from more than one source. The benefits payable under this Plan will not exceed 100 percent of the annual eligible benefits when combined with all other plans.

When Medicare pays as the Primary Coverage, you must first file all charges with Medicare. You will receive an Explanation of Medicare Benefits (EOMB) outlining their payment or denial information. This EOMB must accompany any claim submitted to the Plan for consideration of Secondary coverage.

For covered members who are totally disabled or reach age 65 and are eligible for Medicare and fail to apply for Medicare in a timely fashion, the Municipal Health Benefit Fund will coordinate with Part A, Part B and Part D of Medicare the same as if the covered member had Part A, Part B and Part D of Medicare when Medicare is the Primary Carrier. This means that the Plan will reimburse only 20 percent of the eligible charge and you will be responsible for the deductible and 80 percent of the eligible charge.

The Plan's Administrators have the right to exchange information required to administer this provision with any other party (insurance company, organization or person) to recover any overpayment made to any party.

How Coordination of Benefits (COB) Works

3. This is how COB Works: If more than one group covers you, COB guidelines determine which Plan pays for the covered services first.

   A. Your Primary Plan is the plan paying first; this Plan provides payments towards the balance of the cost of covered services.

   B. Your Secondary Plan is the plan paying second or after the Primary Plan has paid; this Plan provides payments toward the balance of the cost of covered services.

4. This is how to determine which is the Primary and Secondary Plan:

   A. The plan covering the employee is primary. The plan covering the employee as a dependent is secondary.

   B. If both the mother and father's plan cover the child, the plan of the parent whose birthday is earlier in the year is the primary plan.

   C. Children of divorced or separated parents benefits are determined in the following order:

      a. Plan of the parent the court has established as financially responsible for the child's health care pays first (we must be informed of this requirement and documentation will be required).

      b. Plan of the custodial parent.

      c. Plan of the custodial parent's new spouse (if remarried).

      d. Plan of the non-custodial parent.

      e. Plan of the non-custodial parent's new spouse (if remarried).

Coordination of Benefits (COB), continued

If the Primary Plan cannot be determined by using the guidelines above, then the plan covering the child for the longest period is primary. If a group medical plan does not have a Coordination of Benefits provision, that plan is primary.

If you or your dependent has primary coverage but do not follow the Plan benefit requirements of that coverage, Plan's payment will be reduced by 80 percent. In other words, the maximum the Plan will pay is 20 percent of the allowable amount on the claim.

5. Guidelines to Determine Primary and Secondary Plans for Medicare Recipients:

   A. If your Group has less than 20 employees, Medicare is primary for covered members eligible for Medicare due to age.

   B. If your Group has less than 100 employees, Medicare is primary for covered members eligible for Medicare due to disability.

   C. If your group has more than 100 employees, this Plan is primary over Medicare for covered members eligible for Medicare due to age or disability.

   D. A Member eligible for Medicare based solely on end stage renal disease is entitled to receive benefits of this Plan as primary for a 30 month waiting period.

6. COB Allowable Expense: Allowable Expense is a health care expense (including deductible, coinsurance or copayments) covered in full or in part by the Plan. This means an expense or service not covered by any of the Plans is not an Allowable Expense.

Circumstances That May Result in the Reduction or Loss of Benefits:

- Coordination of benefits when a covered person is enrolled in more than one plan and this Plan is not the primary plan.
- Subrogation, reimbursement and third party recovery rights of the Plan.
- Reductions when private hospital rooms are used.
- Reductions for certain multiple surgical procedures.
- Reductions for charges that exceed usual and customary allowances or negotiated fee allowables.
- Reductions and/or denials for services which are not medically necessary or generally accepted as inappropriate and/or are considered as overutilization.
- Denial for services, treatments, medications and supplies that are excluded under the Plan.

Notice and Proof of Claim

Filing a Claim—All claims are to be filed with the Plan Administrator and mailed to Municipal Health Benefit Fund (MHBF), P.O. Box 188, North Little Rock, AR 72115. For any questions, you may call 501-978-6137. All claims, along with supporting information/documentation must be received in the Municipal Health Benefit Fund office or by the Plan Administrator within 180 days of the date the claim was incurred, unless defined otherwise in this section. Please note that the timely filing guidelines also applies to secondary payer rules (COB, as outlined within this booklet.) If an entire group or individual member is terminating coverage, any incurred claim for benefits must be filed within 60 days of the last day of membership in the Plan, or within the 180 days of the date of service, whichever is less.

The Plan Administrator may provide forms to facilitate a claims determination. If a form or supplemental information is requested by the Plan Administrator, all forms must be completed and returned in a timely fashion (as defined by the requesting letter or form and are subject to the limitations in the above paragraph) before a claims determination will be made. The member may request forms to facilitate a claims determination.

Failure to file a claim as required above, will cause the claim to be denied unless the member can present written proof that it was not reasonably possible to give notice or proof within the required time period.

Notice and Proof of Claim, continued

No legal action will be brought against the Plan prior to 60 days after proof of claim has been filed with the Plan Administrator. If the time for beginning legal action is less than that permitted by law of the jurisdiction in which the Municipal Health Benefit Fund is domiciled, such limit is extended to the minimum period permitted by such law.

Payment of Benefits—Benefits will be paid to you promptly upon receipt of due written proof of claim. The member is responsible for reimbursement to the Plan to the extent of any overpayment that is in excess of the amount payable under the Plan. If any benefit remains unpaid at your death, or if you are a minor or, in the opinion of the Plan Administrator, are legally incapable of giving a valid receipt and discharge for any benefit, the Administrator, may at his option, pay all or any part of such benefit (a) to your guardian or your estate, (b) to any institution or individual toward satisfaction of whose charges payment of such benefit is based, or (c) to any one or more persons among the following relatives: your spouse, parents, children, brothers, or sisters. The Administrator's obligations will be completely discharged to the extent of such payment, and the Administrator will not be required to see the application of the payment.

Assignment—Benefits that are not based on expenses incurred may not be assigned. However, benefits payable to you for expenses incurred in connection with a specific period of disability, hospital, surgical or medical treatment, resulting from one injury or period of illness of a covered member, may be assigned by you to the institution or individual furnishing the respective services or supplies for which such benefits are payable, otherwise such benefits may not be assigned. The Plan Administrator assumes no responsibility for the validity of any assignment, nor will he be liable under assignment, until and unless satisfactory proof of assignment is submitted to the Administrator prior to payment of the assigned benefits. Any payment made by the Administrator prior to receipt of satisfactory proof of assignment will completely discharge the Administrator's obligations to the extent of such payment and the Administrator will not be required to see the application of the payment.

Policies and Appeals Procedure—The five-member Board of Trustees of the Municipal Health Benefit Fund Trust will establish policies and hear appeals.

Mandatory Administrative Appeals Procedure

If a disputed claim or benefit question cannot be resolved, there is a formal appeals procedure. As a condition to all the benefits, terms and conditions of this contract, an employer member and its employee members must agree to exhaust all their administrative remedies including, but not limited to, the claims denial procedure before the Board of Trustees, before any legal action is brought in any court.

A denial of a claim for benefits will be explained in writing. The explanation will include the specific reason for the denial. The explanation may also provide a description of additional information you might be required to provide for reconsideration of your claim and an explanation of why it is needed. If you have a question about your claim payment or how the Plan works, we urge you to call and visit with a MHBF Customer Service Representative. If a claims question cannot be resolved through Customer Service, the following claims appeal procedure will be followed.

First Written Appeal—To request a written appeal, address a letter to the attention of the Claims Supervisor, at Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115. The request must be submitted within 60 days of your receipt of the claim denial notice. In your request for review and appeal specifically state why you believe the denial was incorrect.

The Claims Supervisor will normally respond to your request with a decision in writing within 60 days referencing the Plan provision upon which the denial was based and an explanation of the Plan's claim appeal procedure. If an extension is needed to investigate the facts, you will be notified of the need.

Final Appeal—If the decision rendered by the Claims Supervisor is not satisfactory, you or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a review to the Plan Administrator and the Municipal Health Benefit Fund Board of Trustees. The request should be directed to the Plan Administrator at P.O. Box 188, North Little Rock, AR 72115. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and issues outlining the basis of the appeal may be submitted. You may have representation throughout this review procedure.

Your request for review must be filed within 60 days after receipt of the written notice of denial from the Claims Supervisor. You need not appear at the quarterly meeting of the Board of Trustees to have your claim reviewed by the Board. The Board will reach a decision on your claim no later than 180 days after receipt of the request for the Board's review. If there are special circumstances, the decision shall be rendered as soon as possible. The decision after the Board's review shall be in writing and shall include specific reference to the pertinent Plan provisions on which the decision was based.

Overpayments: Right of Recovery

As discussed more fully herein, the Plan specifically excludes from coverage any illness or injury for which a "third party" may be liable or legally responsible. For this purpose, "third party" means a person or organization other than the participant or insured who suffers the loss. If you or your dependents receive payment, expect to receive or seek payment from a third-party insurer, surety, or other type plan for medical expenses resulting from such illness or injury, you should not submit a claim under this Plan for such medical expenses. However, the Fund, at its sole discretion, may provide benefits according to Plan terms provided that the participant agrees, in writing:

- To give the Plan written notice whenever a claim against a third party is made for damages as a result of an injury, sickness or condition.
- The participant or insured agrees to promptly notify the Plan Administrator as to whether the participant or insured or anyone acting on his/her behalf is pursuing or intends to pursue an action against, or to seek recovery from, any third party for damages, indemnity, recovery, insurance, or other payment of any kind whatsoever in connection with the accident, injury, or other event giving rise to the Plan's obligations to make expenditures to or on behalf of the member, so that the Plan can protect its rights to recover.
- Nothing in this section shall be deemed to waive or otherwise diminish any rights to reimbursement, subrogation, assignment, or other recovery available to the Plan under applicable common or statutory laws.
- That the Plan will be treated as subrogated to the extent of benefits paid and any rights of recovery that the participant may have against a third party.
- As a condition to receiving benefits from the Municipal Health Benefits Plan, each participant, former participant or other person having an interest in or eligibility under the Plan ("member") agrees that the Plan will be treated as subrogated to the extent of benefits paid and any rights of recovery that the participant may have against a third party, and that, in the implementation of such subrogation right, the Plan may directly pursue recovery against such third party and can treat the participant (and such individual's attorney) as acting as the Plan's agent with respect to the prosecution of any claim and the recovery of any amount, and that the participant will execute such further documents as may be necessary to effectuate the Plan's subrogation right.
- To reimburse the Plan in accordance with these provisions.
- Notwithstanding and in addition to the above, in the event you receive a benefit payment that exceeds the amount you have a right to receive, the Plan retains the right to require you to return the overpayment or to reduce any future benefit payments made to you or your dependents by the amount of the overpayment. This right does not affect any other right of recovery with respect to such overpayment. You are required to produce any instruments or papers necessary to ensure this right of recovery.
- As a condition to receiving benefits from the Municipal Health Benefits Plan, each participant, former participant or other person having an interest in or eligibility under the Plan ("member") shall provide the Plan with a Right of Reimbursement and an Assignment of Rights, as described below. These rights enable the Plan to recover the amount it has expended to provide the benefits to the member from any proceeds the member receives from a third person in connection with the accident or injury.
- The Plan will refuse to provide the participant or other covered members of the participant's family any benefits under the Plan if the participant refuses to execute an agreement agreeing to reimburse the Plan, fails to reimburse the Plan, or fails to cooperate in helping the Plan collect reimbursement from the participant or a third party.

Right of Reimbursement

As a condition to receiving benefits from the Plan and by their receipt of said benefits, all participants and insureds grant the Plan the right to recover from any proceeds, including any form of consideration whatsoever, that the participant/insured receives from a third party, via judgment, settlement, or otherwise in connection with the accident, injury or other event that resulted in the Plan's expenditures, dollar for dollar beginning with the first dollar received by the member from the third party, regardless of how those proceeds are characterized or labeled (e.g., payment of medical expenses, pain and suffering damages, compensatory damages, punitive damages, or any other type of non-economic or economic damages), in an amount equal to the expenditures made by the Plan in providing benefits to the member.

Without limiting the Plan's rights in any way, it is the intention of the parties that the Plan is entitled to recover from any proceeds that the member receives from a third party, regardless of how those proceeds are characterized or labeled or how they are obtained; i.e., judgment rendered by a court, jury, or other judicial tribunal; awards given or reached in arbitration, mediation, or any other form of dispute resolution, whether said awards were given by the person deciding the outcome of the dispute resolution or by the parties to that process; settlement, or any other arrangement.

It is an additional condition to receiving benefits under the Plan that the member grant the Plan a first lien with respect to any proceeds that the member receives from a third party in connection with the accident, injury, or other event that gave rise to the Plan's expenditures, so that every such dollar of any such proceeds will be paid to the Plan, beginning with the first dollar and continuing until the Plan has been paid an amount equal to the amount it expended to provide benefits to the member, regardless of how that payment is labeled or characterized, regardless of any purported allocation or itemization of such recovery to specific types of injuries, and regardless of the injury or loss ostensibly redressed by the payment or the apparent cause or inducement for such payment. If the recovery is for damages other than for medical or dental care expenses, such as pain and suffering, the participant will still be required to reimburse the benefits paid by the Plan first. The Plan's right of reimbursement will apply to the first dollar recovered from the third party, before attorneys' fees and even if the recovery is less than the amount needed to reimburse the participant fully. The Plan's right of reimbursement will apply to all amounts received from or on behalf of the third party, whether directly or indirectly, including, without limitation, payments to an account or trust on the participant's behalf.

The parties hereby specifically disavow and waive the "make whole" doctrine or any other principle of law that would require that the member be fully compensated before payment is made to the Plan under its Right of Reimbursement or any of its other rights to recovery, whether contractual, legal, or equitable.

In the event a participant or insured fails to provide reimbursement to the Plan under these provisions within a reasonable amount of time after receiving proceeds (including any form of consideration) from any third party, the Plan reserves the right to offset future payments to or on behalf of the participant or other covered members of the participant's family to collect a reimbursement, until it has been fully reimbursed for the expenditures it has made.

In the event a court of competent jurisdiction determines that any part of the foregoing Right to Reimbursement is unenforceable for any reason, it is the intent of the parties that the Plan shall retain all rights provided for in those parts that remain enforceable, including without limitation the Plan's right to recover the expenditures it has made to provide benefits to the member, to the extent that any portion of the proceeds paid to the member by any third party is designated as compensation for medical expenses or for other expenses paid by the Plan to or on behalf of the member, or which are intended as, or can reasonably be attributed to, compensation for medical expenses or other expenses paid by the Plan, though not expressly designated as such, which determination shall be made at the sole discretion of the Plan Administrator.

In order to obtain reimbursement, the Plan will take such actions as the Board of Trustees, in its discretion, feels would best serve the Plan. The Plan may seek to have any payment by a third party made payable to the Plan in lieu of, or in addition to, the participant or his/her assigns or representatives.

Assignment of Rights

In addition to providing the Right of Reimbursement described above, and as an additional condition to receiving benefits from the Plan, the member will assign to the Plan any and all rights to pursue an action or claim against any third party in connection with the accident, injury or other event that gave rise to the Plan's expenditures. If the Plan pursues any such action or claim, the member shall cooperate and assist the Plan and shall be prohibited from taking any action that would prejudice the Plan's rights or in any way diminish its prospects for a recovery.

In addition, the participant must execute a lien in favor of the Plan for the amount to which the Plan is entitled. However, even if the participant or insured does not give the Plan a lien, the participant is liable to the Plan for reimbursement under these provisions:

- To ensure that any amounts received from or on behalf of a third party are kept separate and are not commingled with any other funds.
- To notify the Plan within 10 days after receiving any recovery from or on behalf of a third party.

NOTE: The foregoing provisions are not intended and shall not be deemed to constitute a waiver of the Plan's right to deny coverage for any illness or injury for which a third party may be liable or legally responsible, as discussed above, or for any other illness or injury that is excluded under the terms of the Plan. In no event shall the foregoing language be deemed to vest a participant or other covered members of a participant's family with the right to receive coverage for claims that are specifically excluded under the Plan.

Furthermore, notwithstanding the above provisions, the Plan reserves the right to seek reimbursement for any and all over-payments which it may make by, inter alia, offsetting future payments to or on behalf of the participant or other covered members of the participant's family, until it has been fully reimbursed for the expenditures it has made.

Section 4, General Eligibility Information

General Eligibility Information

Eligibility Dates—If you are an employee in an Eligible Class, you will become eligible for Employee benefits on (a) the date your Employer becomes a Participating Employer or (b) the first day of the calendar month following the date you have continuously been a member of such class for 60 consecutive days (with the exception of February), whichever is later. Waiver of any Plan requirements with respect to coverage of pre-existing injuries, illnesses or conditions does not constitute a waiver of any and all other Plan provisions or exclusions.

The eligibility requirements for employees also apply to Classes 1-5, subject to the provisions below.

Eligible Class—The Eligible Class of employees includes all full-time active employees (Class 5) who work an average of 30 hours per week for a Participating Employer. Any of the following classes can be covered when the following criteria are met:

Since all eligible employees must be offered coverage, the Plan will require the following:

1. All eligible employees have been offered coverage, and
2. A list of all eligible employees taking coverage has been submitted to the Plan, and
3. A list of all eligible employees opting out of coverage, along with proof of coverage through a spouse, Medicare and/or another carrier has been submitted to the Plan.

Classes 1 through 4 are not eligible for the medical coverage if they are eligible for Medicare. Active elected officials who are on Medicare are eligible for dental, vision, drug card and hearing aid coverage. Enrollment in all parts of Medicare, Parts A, B and D, is required for active elected officials choosing to continue coverage under the dental, vision, drug card and hearing aid coverage benefits. However, 75% of each participating class (2, 3, or 4) must participate for coverage to continue.

- Elected officials—Class 1
- Members of boards and commissions—Class 2
- Volunteer firefighters—Class 3 (See below for further details.)
- Auxiliary police—Class 4
- Full-time employees—Class 5
- Retired members age 55 or over—Class 6 (See Retiree Coverage for further details.)

Members in Class 3—to qualify for coverage under the Plan, volunteer firefighters must actively participate in more than:

- 50 percent of fire calls.
- 50 percent of training sessions.
- Verification of participation must be certified in writing under penalty of perjury by the Fire Chief.
- Certification must be submitted to the Plan each year on or before December 31.

If the Employer/Group offers coverage to any of the Classes 1 through 4, then the coverage must be offered to all members of the class. When coverage is offered to a class, the Participating Employer shall require all members of that class to sign up for the coverage or submit a refusal form. A minimum of 75 percent of classes 2 through 4 must sign up for coverage, or none of the class may be covered. Those persons in Classes 2, 3 and 4 who are eligible for Medicare are excluded from the 75 percent. A group must maintain coverage on 75 percent of each participating class (2, 3 or 4) for coverage or for coverage to continue.

A Participating Employer must offer coverage to all eligible employees working thirty (30) hours or more a week and must ensure the employee's share of the premium does not exceed 9.5 percent of the Employee's current W-2 wages for the cost of the employee only (single) coverage for full-time active employees.

Effective Date Requirements

To be covered you must enroll in the Plan when eligible and agree to make any required premium contributions. If you do not enroll yourself and your dependents before the date you become eligible, you may not enroll until January 1 of the following year or another Open Enrollment period.

If you have single coverage, family coverage may be added on the first day of the month after any of the following Qualifying Events:

1. New dependents acquired via:
    - Marriage
    - Birth
    - Adoption
    - Court Order to provide coverage for an eligible child; Child Support/Medical Support Order
2. Loss of Spouse's health coverage due to loss of their employment -must provide letter from both spouse's former employer showing date employment ended and provide a letter from the spouse's former insurance company showing date employment ended and date health coverage ended. **It is the loss of health coverage, not the loss of employment that makes this a qualifying event**.

If you are married with family coverage, an eligible newborn can be added to your coverage on the newborn's date of birth. The newborn must be added within 30 days of their date of birth regardless if Social Security Number is received or not.

Change of Status form and copy of supporting documentation of the Qualifying Event is required within 30 days of the date of the Qualifying Event.

If you do not add the newly acquired dependent(s) by submitting a completed Change of Status Form within 30 days of when they become eligible, you may not enroll them until January 1 of the next year or the next Open Enrollment period.

Members moving from one covered group to another without a lapse in coverage do not have to meet the 60 day employment requirement. If this provision applies to you please contact the Plan Administrator for additional information.

Special Notice—Coverage will not be changed for the member to add or drop family coverage without the member's and/or the Participating Employer's notification at the time of the event. The Plan will not credit premiums for failure to notify the Plan as required.

Family Medical Leave Act—The Plan recognizes and complies with the Family Medical Leave Act of 1993 for groups who employ 50 or more employees for at least 20 work weeks in the current of preceding calendar year. Your Employer must notify the Plan in writing at its Administrative offices if you have left your employment under provisions of the Family Medical Leave Act.

COBRA—The Plan recognizes and complies with all extended coverage benefits for employees and dependents provided for by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Benefits do not include Life and/or disability income.

Certificate of Group Health Plan Coverage—Under the 1996 HIPAA regulations, the Plan will provide a terminating member a "Certificate of Group Health Plan Coverage." You may need this certificate for enrolling in a new plan or in purchasing insurance. Ask your Employer for details.

When Your Benefits Stop

When an employee's employment or salary ceases, the employee's coverage also ends, albeit on the last day of the month in which the employment or salary ceases, whichever is the earlier date. Coverage ends whether you leave your employment, retire, die or go on unpaid leave of absence. If you become a member of an ineligible class, coverage will end on the last day of the month in which you became a member of an ineligible class.

In addition to the above, coverage is also terminable for failure to make premium payment. Coverage for you will stop on the earliest of:

- The last day for which your premium has been paid.
- When the participating Employer fails to make the required premium payments.
- When the participating Employer cancels coverage under the Municipal Health Benefit Fund.
- The last day of the month you cease to meet the eligibility requirements as defined herein.

Your Dependents' Benefits will automatically terminate on the earliest of:

- The date your personal benefits terminate.
- The last day for which your dependent's premium has been paid.
- The last day of the month following your termination from the payroll of the city.
- The date coverage for dependents is terminated under the Municipal Health Benefit Fund.
- For any dependent, the last day of the month he or she ceases to be an eligible dependent.
- The last day of the month you cease to meet the eligibility requirements as defined herein.

Eligibility as a dependent will cease:

a. For any dependent, on the date he or she becomes covered individually under the Municipal Health Benefit Fund, enters active service with the armed forces of any country or otherwise ceases to be in a covered classification according to the definition of an eligible dependent;

b. For your spouse, the end of the month following the date of divorce or legal separation; and

c. For your child, the end of the month following the attainment of the applicable maximum age limit.

However, if your child is incapable of sustaining employment by reason of mental retardation or physical handicap following attainment of age 26 and if covered hereunder up to that time, will continue to be eligible as a dependent so long as he or she remains continuously in that condition, provided the member/employee notifies the Plan Administrator and such condition actually exists. If there is a conflict between dates when coverage could end, the earliest date governs. Additionally, the Plan will not pay for services or supplies furnished after the date coverage ends, even if the Municipal Health Benefit Fund precertifies or provides benefit information for a treatment plan submitted before the end of coverage.

Right to Continuation Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the most current Fund Booklet or contact the Plan Administrator.

The COBRA notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice which will be mailed to you at your last address on file, generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee becomes entitled to Medicare benefits (under Part A, Part B or both), the Employer must notify the Plan Administrator of the qualifying event.

Notice Must Be Given of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child is losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Plan Administrator

Municipal Health Benefit Fund

P.O. Box 188

North Little Rock, AR 72115

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How much does COBRA continuation coverage cost?

You shall be required to pay the entire cost of the continuation coverage. The amount a qualified beneficiary is required to pay may not exceed 102 percent (or, in the case of an extension of coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant of beneficiary who is not receiving continuation coverage.

When and how must payment for COBRA continuation coverage be made?

If you elect continuation coverage you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the employer or the Municipal Health Benefit Fund premium office to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments must be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first (1st) day of each calendar month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send a monthly notice of payments due for these coverage periods to the participating employer along with their regular monthly premium notice.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan may be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the participating Employer for your group. Please do not send them direct to the Municipal Health Benefit Fund address. Payments mailed directly to this address will be returned unless previous arrangements have been made.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES—In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Additionally, if you have changed marital status or you or your spouse have changed addresses, please notify the Plan Administrator in writing at the above address.

IF YOU HAVE QUESTIONS

For questions concerning your Plan or your COBRA continuation coverage rights, please contact your Employer, or the Plan Administrator, Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72215. For additional information about your rights under COBRA or the Health Insurance Portability and Accountability Act (HIPAA), contact the U.S. Department of Health and Human Services at:

www.cms.hhs.gov/COBRAContinuationofCov/ or www.cms.hhs.gov/HIPPAGenInfo/

Retiree Coverage

Arkansas law requires municipalities to establish by ordinance, or otherwise, criteria for eligibility as a retiree. The Plan will provide retiree coverage consistent with locally established criteria provided a written copy of the ordinance or policy is furnished to the Plan by January 1 of the Plan year. If no ordinance or policy is provided, then the Plan will provide retiree coverage if the retiring municipal official or employee:

- is age 55 or older and has completed 20 years of service with a participating Employer.
- is receiving a retirement benefit from the Arkansas Local Police and Fire Retirement System, Arkansas Public Employees Retirement System or a local pension fund.
- pays both the Employer and employee contribution to the health care plan.
- is not covered at any time during retirement by another health care plan.
- notifies the Employer within 30 days after the official date of retirement of their intent to participate in the health care plan of the municipality. The retired employee or official may include his or her dependents in the retiree's health care plan provided the dependent premium is paid.

Section 5, Definitions

Definitions

Actively Working means the active expenditure of time and energy by the employee performing each and every duty pertaining to the job in the place where and the manner in which such job is normally performed. For an employee to be actively working, they will be required to work an average of 30 hours per week on a regular basis and receive a payroll check for such service. If the employee is not receiving a payroll check, they will be considered inactive, and their benefits will be terminated as defined in the Plan.

Acupuncture means puncture treatment or therapy with long, fine needles.

Advanced Practice Nurse (APN) means a person who is licensed as a registered professional nurse under the state in which they are practicing, meets the requirements for licensure as an advanced practice nurse and has a written collaborative agreement with a collaborating physician in the diagnosis of illness and management of wellness and other conditions as appropriate to the level and area of his or her practice.

Allowable Expenses means the usual, customary and reasonable charges, including the average wholesale price (AWP) made for necessary health care services, medications and supplies, a portion of which is covered by at least one of the plans covering the member for whom the claim is made. These covered services will be considered Allowable Expenses and a benefit paid. Allowable Expenses do not include charges used to satisfy the deductibles, copayments or coinsurance assessed under the Prescription Drug Card Plan. (For more information, see Coordination of Benefits.)

Average Wholesale Pricing (AWP) means allowable amount determined by the Plan for products provided to the covered members, employing the most current Average Wholesale Price (AWP) or another industry-accepted benchmark as set forth by Medispan, First Databank, or other industry-accepted database. The Plan retains the right to audit any and all claims for such products provided to its covered members.

Benefit means the benefit provided under the Municipal Health Benefit Fund.

Employee Benefit means the benefit provided for eligible employees.

Dependent Benefit means the benefit provided for dependents of eligible employees.

Certificate of Creditable Coverage means a written certificate issued by the Plan, or another health insurance issuer, that shows your prior health coverage (creditable coverage). A certificate will be issued automatically and free of charge when you lose coverage under the Plan, when you are entitled to elect COBRA continuation coverage or when you lose COBRA continuation coverage. A certificate will also be provided free of charge upon request while you have health coverage or within 24 months after your coverage ends.

Clean Claim is a properly completed billing form UB 94, HCFA 1500, or their successor form(s), or one providing equivalent information with complete and current CPT or ICD coding, which needs no additional information or clarification from Provider or Covered Individual for payment to be made properly, i.e., medical records, detailed billing, invoices, or any other such like information.

Coinsurance means the ratio (percentage) of splitting the bill between the Plan and the covered member.

Example: 80 percent for the first $5,000 of eligible charges means the Plan will pay $4,000 and the covered member is responsible for the remaining $1,000.

Copayment means an amount required to be paid by a covered member each time a specific covered service is accessed. The copayments are set forth in the Schedule of Benefits.

Covered Person means a member covered by the Municipal Health Benefit Fund provision in which the term is used, but only while under such provisions.

Custody means the care, control and maintenance of a child that may be awarded by a court to one of the parents or a guardian.

Dentist means any physician as otherwise defined in this booklet practicing within the scope of their respective profession who performs a dental procedure covered by the Municipal Health Benefit Fund.

Elective Procedure means a medical procedure to improve health or quality of life when the medical condition is not considered immediately life-threatening. Elective procedures are pre-scheduled to a specific date and are not considered emergent in nature.

Eligible Dependent—An Eligible Dependent is as follows:

- Spouse—not legally separated or divorced
- Child—under the age of 19 years
- The term Child shall include:

  a. An employee's natural child from birth less than 19 years of age.

  b. An employee's adopted child or stepchild under legal guardianship, if such child depends primarily on the employee for support and maintenance and lives with the employee in a regular parent-child relationship. A divorce decree is required to note legal custody and insurance maintenance at enrollment of said child.

  c. Adopted children and stepchildren ages 19 to 26 must have met the above requirements at the time the child turned 19 to be considered an Eligible Dependent. Copies of supporting documentation will be required for these dependents.

  d. An employee's grandchild who is under legal guardianship or custody of the employee and may be enrolled under the Dependent Only coverage if the employee submits documentation of custody and/or guardianship and pays an additional monthly premium as determined by the Plan.
- Adult Dependent—a covered dependent (other than your spouse) age 19 to 26.

  a. Coverage for adult dependents (other than your spouse) age 19 through the last day of the month in which they reach age 26 can be covered, at the employee's request, under the Major Medical and Prescription Drug Benefits of the Plan.

  b. An Adult Dependent Status Form will be required at the time of enrollment and by December 1 of each year for coverage to continue. If this form is not received, coverage will end December 31 of the current coverage year.

The following are **NOT** Eligible Dependents:

- anyone who resides outside the United States or Canada;
- is in the armed forces of any country;
- has coverage under the Municipal Health Benefit Fund as an employee or as a dependent of another member; or
- Adult Dependents (other than your spouse) who have access to medical coverage through their or their spouse's employment or Medicare, even if they choose not to take the other coverage.

Employee—See member/employee.

Employer means only the Plan or a participating affiliate of the Plan who in either instance participates in the Plan as a participating Employer.

Definitions, continued

The terms **Experimental and Investigative** apply to a medical device, medical treatment or pharmaceutical treatment that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA). The Plan Administrator may select a medical review professional to help determine whether a specific treatment is experimental or investigative, but in any event, the decision of the Plan Administrator will be considered final and binding on all parties. After all other provisions of the Plan have been complied with, the following criteria and guidelines will be used by the Plan in determining whether medical devices, medical treatments and pharmaceutical treatments are to be considered experimental or investigative and whether they will or will not be covered by the Plan.

If FDA approval for use of a drug to treat a specifically diagnosed condition has not been given at the time of treatment, such use shall be known as "off-label" use and will not be covered by Municipal Health Benefit Fund.

The Plan will not provide coverage for medical services that are subject to ongoing clinical trials or research.

The Plan will not provide coverage for medical devices unless all of the following criteria are met:

a. The FDA has approved the device for marketing.

b. The device is being used to treat a condition specifically recognized and authorized by the FDA marketing approval.

c. The device has been recognized for its clinical effectiveness in treating the condition according to the nationally accepted medical guidelines utilized by the Plan.

Fund Month means a period of one month beginning on the date regular monthly premiums became due under the Municipal Health Benefit Fund.

Guardian means a person lawfully invested with the power and charged with the duty of taking care of a child and managing the property and rights of that child.

Homebound means that leaving home is a major effort; you are normally unable to leave home unassisted and you are unable to go to work; when you leave home, it must be to get medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services.

Home Office means the Home Office of the Plan Administrator.

Home Setting means medical care provided in the home.

Hospice Care means medical care of dying persons while allowing them to remain at home under professional medical supervision.

Hospital means an institution operated according to law that regularly provides continuous room and board and nursing service for its patients; has a staff including one or more physicians available at all times; is equipped with organized facilities on its own premises for diagnosis, therapy and/or major surgery; and is not primarily a clinic, nursing, residential treatment or convalescent facility, or an institution for treatment of alcoholism or drug abuse.

Hospital Care Period means successive periods of hospital care for illness or injuries due to the same or related causes unless such periods of hospital care are separated by at least 60 consecutive days or, in the case of an employee, by at least one day of active work with the employer.

Hyperbaric Oxygen Treatment means a medical treatment that allows patients to utilize pure oxygen inside a pressurized chamber.

Illness means illness or disease and related medical conditions.

Immediate Relative means your spouse, parents, children, brother, sister, grandparents, uncles, aunts, nieces, nephews or legal guardian of the covered member who received the services.

Injury means a bodily injury sustained accidentally by external means.

Inpatient means a member who is a patient using and being charged for the daily room and board facilities of a hospital or a member who remains in observation longer than 23 hours.

Licensed Certified Social Worker means a person who has a Master's Degree from an accredited social work program in an accredited institution approved by the state in which they are licensed to practice. This definition shall also extend to licensed certified counselors. To qualify for benefits, the Plan member must have been referred to the social worker by a licensed medical physician.

Long-Term Care (LTC) means the provision of medical, social, and personal care services on a recurring or continuing basis to persons with chronic physical or mental disorders. The care may be provided in environments ranging from institutions to private homes. Long-term care services usually include symptomatic treatment, maintenance, and rehabilitation for patients of all age groups.

Maintenance Therapy means a therapeutic regimen intended to preserve the patient's functionality so that the patient continues in good health practices without supervision, incorporating them into a general lifestyle.

Medicare Eligibility means when an individual meets certain criteria that will enable him or her to apply for and receive Medicare benefits, such as turning 65 or becoming disabled.

Medicare Entitlement means when an individual becomes entitled to Medicare once they actually apply to begin Social Security income payments or file an application for hospital insurance benefits under Part A of Medicare.

Member/Employee means an eligible person or their dependent who has submitted an enrollment form and has been accepted as a member of the Municipal Health Benefit Fund, and remains a member in good standing according to the policy provisions of the Plan. In addition to full-time active employees who work at least 30 hours per week for a participating employer, those eligible for membership also include elected officials, members of a board or commission, volunteer firefighters, auxiliary police or retirees.

Month means the period of time from the beginning of a numbered calendar day of a calendar month to, but not including, the same numbered day of the following calendar month.

Morbid Obesity is defined as a condition for which a Covered Individual is over their ideal weight with a Body Mass Index (BMI) of greater than 35 to 40.

Municipal means pertaining to a local governmental unit or political subdivision, e.g., incorporated cities and towns of Arkansas and Arkansas counties.

Nutritional is defined as (1) the process of nourishing or being nourished, especially via the process by which a living organism assimilated food and uses it for growth and for replacement of tissues; or (2) the science or study that deals with food and nourishment, especially in humans; or (3) a source of nourishment, food; and (4) the provision to cells and organisms of the materials necessary in the form of food to support life. Many common health problems can be prevented or alleviated with a healthy diet.

Occupational Therapist means a person who helps patients to develop skills in carrying out activities of daily living, vocational skills and fine motor hand skills. They also make and apply orthoses and treat psychologically impaired patients.

Occupational Therapy means a therapeutic use of self-care activities to increase independent function, enhance development and prevent disability.

Outpatient means a member receiving services or treatment for care of illness or injury in a hospital or other licensed facility.

PHI means Personal Health Information.

Definitions, continued

Physical Therapist means a doctor or an individual licensed by the proper authority or certified by the American Physical Therapy Association.

Physical Therapy is a rehabilitation treatment that improves further deterioration of a bodily function that has been lost or impaired through a disease or injury. This treatment involves physical contact with the impaired area such as massage, manipulation, heat or hydrotherapy.

Physician means a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place service is rendered. Physician also means a licensed doctor of podiatry (D.P.M.), a licensed chiropractor (D.C.), a licensed psychologist (Ph.D.), a licensed oral surgeon (D.D.S. or D.M.D.), a licensed doctor of optometry (O.D.) and a licensed doctor of psychiatry (M.D. Psychiatrist).

Plan is defined as the **Municipal Health Benefit Fund (Fund)**, as presented in the Employees' booklet as approved by the Board of Trustees.

> ***Plan other than the Municipal Health Benefit Fund (Fund)*** means any group insurance or group prepaid arrangement of coverage, whether on an insured or uninsured basis, which provides benefits or services for, or by reason of medical, dental, or vision care or treatment, or any coverage required or provided under, or by any government program or law, including Medicare. Hospital indemnity benefits (provided on a non-expense incurred basis) of $30 per day or less are not included within the meaning of "Plan." Each policy, contract or other arrangement for providing benefits or services will be considered a separate Plan. If only a part of such policy, contract or other arrangement is subject to a provision similar to this provision, that part will be treated as one Plan and the remainder will be treated as a separate Plan.

Pre-Determination means to determine in advance that a member is eligible to participate in a covered program.

Precertification means PRIOR notification to the Utilization Review Program before any of the service types listed in the Fund Booklet are received by the covered individual.

Pregnancy means the state of a female after conception until delivery and/or until termination of gestation.

Room and Board Charges means charges incurred by an inpatient for room and board and other services and supplies necessary for the care and treatment of illness or injury, except fees for professional services that are customarily made by a hospital at a daily or weekly rate determined solely by the class of accommodations occupied.

Satisfactory Evidence of Coverage means evidence that is approved by the Plan Administrator at his Home Office and is furnished without expense to the Plan Administrator.

Speech Pathologist means a person who has been educated, trained and licensed to plan, conduct and evaluate speech therapy programs.

Stop Loss is a limit on the coinsurance required from the Covered Member.

Surrogate Pregnancy is acting as a substitute mother by becoming pregnant for the purposes of bearing a child on another's behalf.

Usual, Customary and Reasonable Charges (UCR) To determine UCR charges billed by a medical provider for services and supplies, the Plan reserves the right to use national tables (including, but not limited to, RBRVS, ADP and MDR) and methods in accordance with health care industry standards. The Plan may set limits on a provider's charges and fees at its discretion without giving notice to the provider. The Plan will not pay 100 percent of a provider's billed charges.

You and Your means an employee/member covered by or in a class eligible for Employee Benefits.

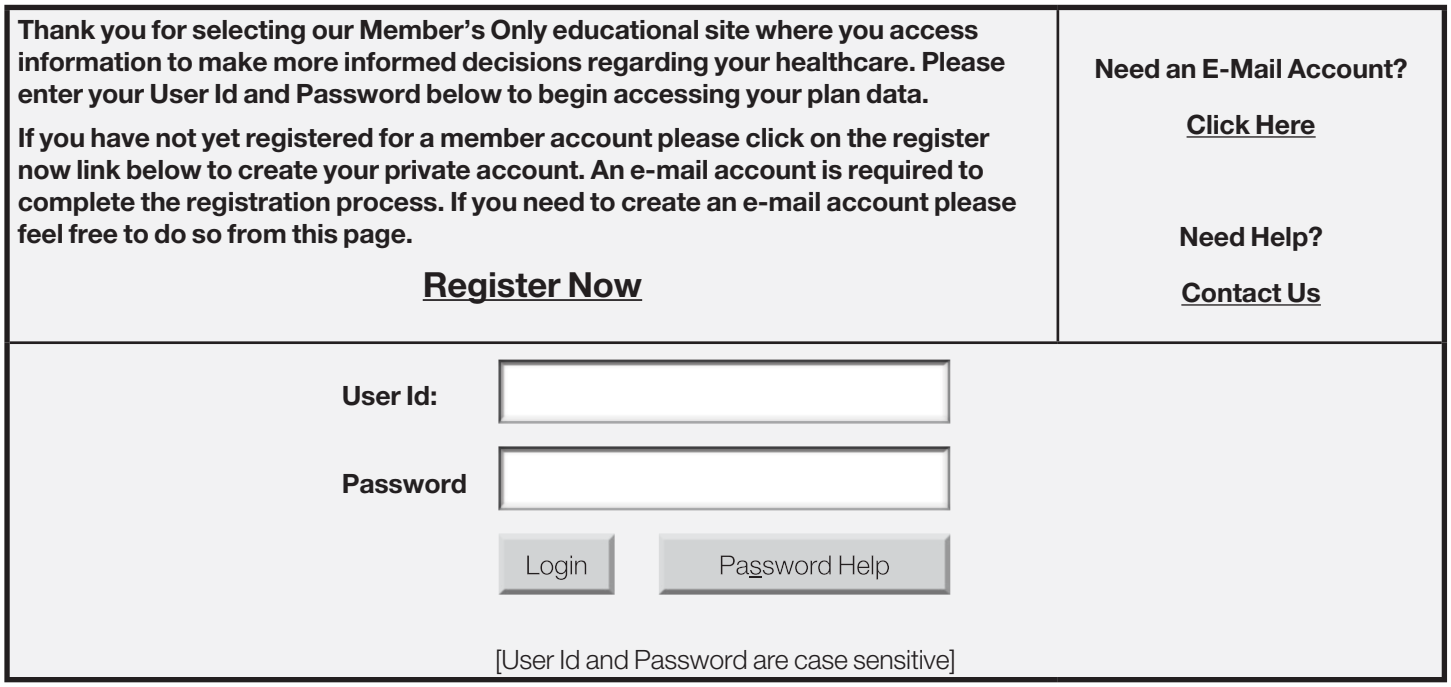
> A glossary of commonly used Health Coverage & Medical Terms is available at www.arml.org or by calling Customer Service at 501-978-6137.

Section 6, Forms

To Print A Temporary ID Card

You may print a temporary ID card from the Restat website if one is needed until the permanent card is received or if an ID card is lost and a card is needed immediately.

Access MemberREPortal: Go to www.restat.com > Member Login (small white print at the top of the page).
Click **Register Now** and complete the registration page, which will look like this:



Contact Restat Customer Service at **855-253-0846** to obtain your unique ID and Rx Group/Plan Numbers.

Print my temporary ID card: Click the Member ID Card link on the left side of your MemberREportal page, a new page will open with your temporary ID card > Print.

Please call MHBF Eligibility and Enrollment at **501-978-6137** if you need to order new cards if your cards are lost or stolen.

Certificate of Notice and Acceptance of Plan Provisions

"CONTINUATION COVERAGE" UNDER COBRA, HIPAA EXEMPTION AND BENEFICIARY DESIGNATION

Effective December 1, 1981 (as Amended January 1, 2013)

This mandatory Certificate of Notice must be signed by all covered members and their spouses as is applicable and then returned to the Employer Member of the Trust.

By signing below, I hereby certify that I have received a copy of the 2013 Municipal Health Benefit Fund Booklet and accept the terms and conditions of the Municipal Health Benefit Fund. I acknowledge the Fund's election to exempt the Plan from requirements of Federal law as listed on the inside cover of this booklet. I further acknowledge that the Plan recognizes and complies with all extended coverage benefits required by the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA).

By signing below, I further acknowledge that although benefits for an illness or condition may have been covered under a previous Plan year booklet, the Plan does not necessarily provide benefits for those illnesses or conditions in a succeeding Plan year. I hereby authorize any hospital, physician or health care provider and/or payer to furnish any information requested by the Municipal Health Benefit Fund that may be necessary to determine benefits payable. This authorization extends to the release of information required to determine benefits payable for my dependants under the age of majority. A photostatic copy of this authorization shall be considered effective and valid as the original for purposes of medical authorization only. This medical authorization shall remain in effect until such time that I revoke it in writing.

Member/Employee:_____ /_____
Signature of Member Social Security Number
(Includes Retiree or COBRA Member) (Includes Retiree or COBRA Member)

Member/Employee:_____ /_____
Print Your Full Member Name Date of Birth

Home Telephone Number: _____Date Signed:_____

Spouse: _____ /_____
Signature of Spouse (if applicable) Spouse Social Security Number

Spouse: _____ /_____
Print Name of Spouse (if applicable) Spouse Date of Birth

Home Telephone Number: _____Date Signed:_____

Please list a Beneficiary and their relationship to you for your Life Benefits

Beneficiary_____/Date of Birth_____
Print Name Clearly S=Spouse C=Child SC=Step Child AC=Adopted Child

This portion is to be completed by Employer Representative and mailed to:
Municipal Health Benefit Fund, P.O. Box 188, North Little Rock, AR 72115

City/Entity of: _____

Group Representative:_____

This form should be returned to your Employer.

MHBF USE ONLY

MUNICIPAL HEALTH BENEFIT FUND

Authorization To Disclose Health Information

P.O. BOX 188, NORTH LITTLE ROCK, AR 72115

Fax 501-537-7252

This form is **OPTIONAL**. By completing this form, a covered individual may allow someone other than themselves or their providers access to their Private Health Information (PHI). **PLEASE PRINT**

Name of Policy Holder: _____ID#/SSN: _____

Group/Employer Name: _____

I _____(name), do hereby give authorization to the Municipal Health Benefit Fund (Plan) permission to disclose any and all Private Health Information (PHI) to the individual name below:

_____/_____

Print Name **Relationship to Member**

(1) I understand that I have the right to revoke this authorization at any time in writing and present my written revocation to the Plan at the address listed above. I understand that the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to the Plan or their lawyers when the law provides the Plan with the right to contest a claim made under Plan coverage. Unless revoked, this authorization will expire on the following date, event, or condition: _____, or at the termination of my employment.

(2) I understand that this form is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment or proper claims payment while I am covered under the Plan. I understand that I may inspect or copy the information to be used or disclosed as provided in CFT164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. If I have questions regarding the disclosure of my health information, I may contact the Plan's designated representative.

Signature: _____ Date: _____

Witnessed by _____ Date: _____

_____
PRINT NAME

Municipal Health Benefit Fund

Revocation of Authorization to Release Health Information

P.O. Box 188, North Little Rock, AR 72115

Fax 501-537-7252

Name of Policy Holder: _____ID#/SSN: _____

Address:_____

Group/Employer Name: _____

I _____, hereby revoke any and all authorizations to release health information to:

_____/_____

Print Name Relationship to Member

I understand this revocation will not apply to information already released in response to the Authorization to Disclose Health Information previously submitted. I also understand this revocation does not apply to the Plan or their lawyers when the law provides the Plan the right to contest a claim incurred while I was a covered member under the Plan.

Signature: _____ Date: _____

Witnessed by _____ Date: _____

_____

PRINT NAME

HIPAA Privacy Notice

The Municipal Health Benefit Fund (MHBF) is subject to the PRIVACY, SECURITY and ELECTRONIC DATA INTERCHANGE components of the Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996. HIPAA requires privacy and security safeguards for Protected Health Information (PHI). PHI is generally defined as "any individually identifiable health information element that is transmitted or maintained in any form that could identify the subject (person) of the information." PHI can include all forms of information, including paper records, electronic records, or oral communications. PHI data elements include such items as name, address, birth date or age, telephone number, medical record number, biometric identifiers, health plan numbers, occupation, photo, employer, etc.

MHBF has adopted sufficient policies, procedures and safeguards (including employee training and sanctions for failure to comply) in order to comply with HIPAA and safeguard member PHI. Under HIPAA, members have the right to access their own PHI (at a time and place and at a cost as determined reasonable by the MHBF) and to request modifications to such records should they find errors. YOUR PHYSICIAN OR MEDICAL INSTITUTION IS THE BEST, MOST COMPLETE SOURCE OF MEDICAL RECORDS INFORMATION.

MHBF takes a "minimum necessary" approach to the release of member PHI. Releases of PHI to persons other than the members themselves will only be made with the express consent of the member, unless required by law, and such releases will be documented. MHBF is not required to, nor will it provide an accounting for disclosures that are made for the purposes of health care treatment, operations or payments. However, MHBF will provide an accounting of any disclosures required by law.

A complaint process is available to MHBF members who believe that a violation of the PHI privacy or security requirements has occurred. The member may notify the Arkansas Municipal League Privacy Officer at League Headquarters in North Little Rock at 501-374-3484. The Privacy Officer will investigate the complaint and ensure that the MHBF Board and the Plan Administrator are aware of the issue and the resolution of the complaint. If you are dissatisfied with the internal resolution, or if you prefer, you may submit a written complaint to the Office of Civil Rights, which enforces HIPAA.

eDocAmerica™

Online Medical Experts - 24hr Nurse Line

What is eDocAmerica?

- *Direct email access to eDocAmerica medical professionals*
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- *Healthy Lifestyle Assessment to help you monitor your current health status*
- *All services are FREE, unlimited, confidential, and cover the entire immediate family*

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- *Toll free access to a registered nurse 24hrs a day, 7 days a week*
- *A registered nurse will advise the caller as to the proper disposition for their situation*
- *English and Spanish speaking nurses*

To access the eDocAmerica Registered Nurse Advice Line, call toll free:

1-866-842-5365

Access your FREE account

Step 1 - Visit www.edocamerica.com

Register Here

Step 2 - Click the "Register Here" button

*Step 3 - Choose "**Arkansas Municipal League**" from the drop-down menu*

Step 4 - Follow the online instructions

eDOC America

Need Help? Have Questions?
1 (866) 525-3362 or info@edocamerica.com

PLAN ADMINISTRATION: Enrollment and Premiums

Municipal Health Benefit Fund Premium
P.O. Box 880
Conway, AR 72033
Phone: 501-978-6137 Fax: 501-537-7252
www.arml.org

CLAIMS ADMINISTRATION: Claims and Benefits

Municipal Health Benefit Fund
P.O. Box 188
North Little Rock, AR 72115
Phone: 501-978-6137 Fax: 501-537-7252
www.arml.org

For Precertification, please call:

1-888-295-3591
(Precertification does not provide Benefit Information.)